Cultural Competence in Health Communication:

Responses by Latino Immigrants on Healthcare Providers' Messaging in the Twin Cities

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Executive summary

Cultural competence is an important and recurring topic for healthcare professionals and providers, especially in communities that serve diverse clients and patients. This discussion is even more critical in institutions that serve predominantly immigrant and minority communities, where the relationships between providers and patients/recipients are complex and challenging when different cultures and ways of knowing and being converge. Focusing on the Latino community in the Twin Cities, the goal of this document is to outline the importance of considering cultural competence and incorporating it as a concept in communication strategies used by healthcare institutions to engage with this specific population.

A qualitative approach, with two focus group discussions, was used to gather opinions and reactions about communication materials by potential Latino consumers. In both groups participants were female, although they were from different socioeconomic backgrounds. Women were the primary sample used because they historically have greater involvement and influence in the healthcare decision-making process at home, and are often the main caregivers that accompany dependents and family members to healthcare visits. Communication materials were mainly print documents, including brochures and handouts, as healthcare institutions tend to produce and distribute these in greater volumes, but the focus groups also watched a video on maternal health services and reviewed a website from a community hospital. During the discussion, and in order to evaluate effectiveness of the communication materials, participants were encouraged to talk about how relevant the information was to their needs and preferences; the appropriateness of the language (Spanish) used: and how likely were they to use the offered services. Towards the end of the focus group, participants discussed the ways in which they

actually get information about healthcare services and how they know where to go when they need such services.

After analyzing their opinions, preferences, and comments, the following three main findings were made. The first looks at what is being communicated, and references the language and concepts conveyed in the materials. According to the female Hispanic participants, they consider it important to create communication strategies that go beyond simply translating language, but instead incorporate other cultural factors. For example, the concept of doula, even when translated into Spanish, may not be familiar to Latino families looking into maternal health services and they may need more context. Of course offering these materials in Spanish is imperative, but not just translating the range of services offered. Often times, translations are conducted using a mechanical process converting text from English to Spanish, missing some of the key cultural uses some of the key words and phrases that exist in Spanish, but not in English.

The second key finding considers how the information is being conveyed, meaning through which mechanisms the information is being related to and by whom. Latinos in the Twin Cities rely predominantly on word-of-mouth when they are seeking healthcare services. This suggests that in engaging with this specific community, clinics and hospitals need to do grassroots work to link services with other community-based institutions in order to gain trust from the potential clients. These healthcare institutions could be better at reaching these communities if they employed communications officers to liaise with these trusted Latino and immigrant serving institutions.

The third finding looks at to whom the materials are being directed, and how they portray and represent these communities in their materials. Communicators from healthcare institutions need to be careful and sensitive to how they reference and represent their target population's

economic status. Low-income families are aware of their socioeconomic position and circumstances, and thus finding overt references to their poverty in materials used to invite them to use health services can be experienced as patronizing and insulting. In summary, while they know they experience poverty, they do not have to be reminded of their situation continually when trying to find services for themselves and their families. A final finding is in regards to gender, and to what sex these materials are designed for. Even though the women participants recognized their important and central role in deciding whether or not to use certain healthcare services for their family, they point out the necessity of incorporating men and, in general, the concept of family into healthcare materials and language. For example, only portraying women in images and languages in brochures, reiterates that healthcare provision is only a woman's job. Making communication materials that include men in the responsibility of healthcare provision makes the content more appealing and more empowering to the entire family. The concept and role of family, or familismo as will be discussed further in this research, is a very specific notion among the Latino community, and should be taken into account by healthcare communicators when they are designing materials for their target audiences. In summary, through this research on how Latino female participants perceive and respond to key communication materials directed at their community, a number of central findings useful for healthcare institutions have been identified; these findings consider issues of translation, cultural competence and what information is communicated; how this information is communicated by healthcare institutions; and how low-income communities and gender are represented in targeting key segments of the Latino population.

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Introduction

The way healthcare providers interact with immigrant populations through communications materials in the United States has caught the attention of researchers at different moments in history, especially during the country's huge waves of immigration. One of the topics most studied has been mental health in immigrant communities. There is a notable body of research on the relationship between one's immigrant status and the incidence of mental health, and how mental health has shaped the way healthcare is being provided to these communities regardless of where they came from and how they came to the U.S. (Chen & Vargas, 2011; Escobar et al., 1999; Hovey et al., 2000). There is also a significant amount of research on how immigrants acculturate to American society and how they adopt eating and nutrition habits from their new U.S. home environment. This of course affects their long-term health outcomes (Pérez, 2014), but can have negative health consequences for them and their families.

The U.S. healthcare system has also adapted to serving different communities that have immigrated, who have thus helped shape the system as their communities expand and become important segments of the nation's population. These immigration trends and phenomena have led to more studies on cultural competence and the way healthcare practitioners treat their immigrant patients (Beamon et al., 2006; Jenakovic, 2001; Rees & Ruiz, 2003; & Tseng & Streltzer, 2008). While much of this research addresses cultural competence among the providers in respect to the patients or users, there is less literature on how cultural competence can affect the way hospitals, clinics, insurance companies, etc. communicate with these varying immigrant communities. In Minnesota, the Latino community is one of the largest minority populations: 5.2% of Minnesotans are Latinos/Hispanics (U.S. Census, 2015). According to the U.S. Census (2015), 8% of the children enrolled in the school system are Latinos, and this population is

projected to grow. Along with other communities, Latinos have shaped the state of healthcare in the state, health care providers still lack information and data on what is the best way to communicate with this target group. Are hospitals and clinics doing a good job reaching the Latino community? Are the ways healthcare providers reach out to Hispanics culturally and socially appropriate and effective? Are Latinos getting all the health services they need? Is awareness of services an outcome of successful communication between healthcare providers and potential clients, or should satisfaction with services and materials also be important? This study will serve as a starting point for examining these questions and for identifying the most appropriate ways to address healthcare communication and messaging with a community that keeps growing in size, not just in Minnesota but also in the country as a whole (Pew Research Center, 2015). For the purpose of this study, the geographical focus within Minnesota will be the Twin Cities as this is where approximately half of the entire Latino population in the state, or nearly 140,000 Hispanics, resides, according to the Minneapolis/St. Paul Business Journal (2013).

Literature Review

Healthcare Communications in a Diverse Environment

Healthcare communications is "the study and use of communication strategies to inform and influence individual and community decisions that enhance health" through providing relevant information to those individuals or communities in order to generate "knowledge, attitudes, and practices with regards to health" (Thomas, 2006, p. 1-2). For some scholars, healthcare communication materials have to align with different characteristics and needs of the audiences, as well as their personalities. For instance, Allen et. al. (2002) points out that personalities may differ, and these individual characteristics can affect the way people see and interpret messages. Along this point, there are people who are more drawn to visual images, while others who prefer reading simple text. This psychological approach to designing messages acknowledges that all people are different, which healthcare providers should take into consideration when producing communications materials for their clients (Allen et. al., 2002). Allen et al. (2012) further states that, "if we can understand those differences we can increase our effectiveness" (p. 4) as healthcare communicators and offer better quality messages tailored to the intended audience.

In contrast, there are other scholars that include more elements than just personality in their analysis about healthcare communication. For example, Cooper et al. (2003) says, "Individuals coming together in medical dialogue bring with them all of their personal characteristics, including their personalities, social attitudes and values, race, ethnicity, gender, sexual orientation, age, education, and physical and mental health. This applies to the physician as well as to the patient" (p. 5). This statement extends to differences beyond solely personality, while at the same time considers (good) health communications to be a complex task. Applying

this to the U.S., a nation of individuals and communities from diverse backgrounds, potential healthcare clients require communications approaches that reflect their different needs and interests. This presents a big challenge for healthcare providers, who have to communicate with a growing landscape of minority groups.

This challenge of providing healthcare to different cultural and ethnic demographics has been explored to some extent in communications and healthcare research. There is consensus around the notion that the U.S. healthcare system is one of the most complicated and expensive in the world, and therefore gaining access to this system is also complicated (Aguirre-Molina et al., 2001; Wallace et al., 2008). These studies conclude that some groups face a lot of barriers in accessing health services in the U.S., and often those barriers are linked to cultural factors and lack of knowledge about how the system works. Aguirre-Molina et al. (2001) also separate, in the specific case of the Latino community, barriers related to economic status. According to recent data in Minnesota the median annual income among Hispanics is $18,000, meaning that one out of four Latinos are living in poverty, more than double the proportion of those living in poverty in the whole state (Minnesota Compass, 2014). From this standpoint, establishing the right communication strategies between healthcare providers and populations that are constantly struggling in terms of health access is of growing social relevance and necessity.

Language

Another recurrent and critical issue when addressing healthcare communications with diverse communities is language. Citing the definition provided by Kramsch (1998), “Language is the principal means whereby we conduct our social lives. When it is used in context of communication, it is bound up with culture in multiple and complex ways” (p. 3). Based on this definition, language is an essential component of our socialization and communication process.

If individuals do not know the language spoken in a specific environment, there are chances that their process of socialization will be compromised. The Pew Research reported in 2013 that in the U.S. almost 35 million Hispanics spoke Spanish at home, an indicator of what language they feel more comfortable communicating in. While this indicator does not measure whether or not the Spanish speakers are also English speakers, it gives a sense of how important the Spanish language is for Latinos in the way they socialize, even though they live in an English-speaking country. In this regard, the healthcare system has tried to adapt to the needs of Latinos by creating Spanish language materials. As such, when visiting some hospitals and clinics it is common to find brochures, posters, videos, or even social media messages in Spanish, especially in institutions located in neighborhoods with a large presence of Hispanics. Here is where communications come into play. Are those materials appropriate for the Latino community just because they are in Spanish? Do Hispanics in the Twin Cities have a good understanding of the healthcare system, even if they are explained in their native language? Do they know all the services they are eligible for when they access these materials in Spanish? For some researchers, language is an important barrier to obtaining health services, but it is not the only one. Thomas (2006) frames the language barrier as a bigger barrier to the different ethnic and cultural profiles of the U.S. population. "Vast differences are likely to be found with regard to knowledge, attitudes and perceptions. These differences are exacerbated by cultural differences unrelated to healthcare that may influence their interaction with the healthcare system" (p. 73).

In regards to Thomas' findings that ethnicity and culture are factors that affect how people interact with the healthcare system, it is important to highlight the idea of cultural competence. This concept has been largely investigated as a necessary competency for healthcare providers that work with diverse communities. For instance, Betancourt et al. (2014)

talk about the necessity of fighting health disparities, and the answer for this inequity gap is cultural competence. Jenakovich et al. (2001) define cultural competence as, "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (p. 6). In 2003, Rees & Ruiz published a report for The Henry J. Kaiser Family Foundation where there is a compilation of definitions on cultural competence. All of these definitions discuss the behavior and attitude of the healthcare practitioners towards the patients, and highlight the accommodations and knowledge the practitioners have to possess in order to improve the quality of the services they provide with the intention of reducing health disparities (Rees & Ruiz, 2003). The reasoning is simple: practitioners with high cultural competence are likely to offer higher quality health services to diverse communities.

One author who in the recent history of healthcare has elevated awareness on the importance of cultural competence is Anne Fadiman. In her book "The Spirit Catches You and You Fall Down" (1997), she explains how a Hmong family struggled at the beginning of the 1980's to provide appropriate treatment to their child that suffered epileptic attacks. In her story, Fadiman describes how the healthcare system in California was not able to connect with and meet this Hmong family's needs. It is worth remembering that during the 70's and 80's, the U.S. government granted refugee status to a large number Hmong families who were collaborators with the American military during the Vietnam War. The Hmong were resettled in different locations, mostly California, Minnesota, and Wisconsin, and at the time the book was written the phenomenon of Hmong resettlement in the U.S. was still relatively new. Language issues were just one part of the problem. Understanding each other's beliefs and religions, and negotiating medical authority among U.S. doctors who perceived they were superior to the patients in terms

of knowledge and education were some of the obstacles presented in this book. This is what cultural competence tries to combat, these different positionings of professional and social dominance. At some point, the writer describes that not even having interpreters was enough to create a bridge between the doctor's instructions and the Hmong family's cultural beliefs and practices. Fadiman's book became an essential work on cultural competence and now every new student of the Yale School of Medicine is required to read it (The New York Times, 2012). Thanks to this shift in the discussion, some academics are now linking cultural competence with ethics in the healthcare practice, acknowledging that "minorities often receive a lower quality of health care than do their white counterparts" (Betancourt et al.. 2014, p. 144), which facilitates health disparities based on cultural and ethnic differences, as well as economic. "Cultural competency is therefore a mechanism to ensure the observance of consumer rights, such as the right to respect and nondiscrimination," (Brach & Fraserirector, 2000, p. 183), and is considered a necessity for closing the healthcare provision gap.

While other authors agree with this same view of cultural competence from a practitioner's perspective (Ahmed & Bates, 2012; Beamon, 2006; Jeffreys, 2016; Tseng & Streltzer, 2008), there is little research suggesting that healthcare institutions should incorporate cultural competence into their communication strategies and materials in order to reach diverse communities.

Health Beliefs Model and Reasoned Action Theory

The intention of this research is to analyze the reaction of some Latinos in the Twin Cities towards communications materials created by healthcare providers. Several authors have used the Health Beliefs Model (HBM) to explain the process of decision- making when receiving healthcare services. The HBM was created at the beginning of the 1950's by Godfrey

Hochbaum, Stephen Kegels, and Irwin Rosenstock. This theory proposes "that, in general, behavior depends on how much an individual values a particular goal and on his or her judgment that a particular action will achieve that goal," (Poss, 2001, p. 2). This model is based on self-identifying **perceived susceptibility** to a specific health condition, **perceived seriousness** of the illness, **perceived benefits of taking action**, **barriers to taking action**, and **cues to action** or information that triggers the health behavior (Rosenstock, 1974). Romano & Scott (2014) conducted a study to investigate how to use the HBM to reduce obesity among African-American and Hispanic populations. In their findings, one of the main aims is to engage Hispanics in healthy behaviors based on cultural perceptions of what a healthy weight is in the U.S. and what healthy eating patterns are in the U.S. Their impetus of studying Hispanics and African-Americans is that they are typically from lower socioeconomic statuses and therefore likely are overweight and have unhealthy eating habits (Romano & Scott, 2014). Even while these authors mentioned the cultural component in their research, there are other researchers that have found that the cultural gap is not integrated as an overarching factor in the HBM. For instance, Jane Poss (2001) states that, "another criticism of the HBM is that it does not account for normative or cultural factors that may be important in explaining health-seeking behavior. Although Rosenstock states that a person's beliefs about risk-reducing behaviors are undoubtedly influenced by the norms and pressures of his or her social groups, a normative concept is not explicitly included in the HBM," (p. 3). However, this argument did not stop Romano & Scott from building a cultural connection with the HBM theory.

There is another behavioral theory that presents similar characteristics to the HBM. This is the Theory of Reasoned Action (TRA), introduced by Fishbein and Ajzen in 1975. According to this theory, people move towards action following five steps starting with having an **attitude**;

then evaluating the **perceived norms** (what is accepted in the environment, what are the expectations of my actions); thereafter moving towards **perceived behavioral control** or how capable an individual is in making a decision; then showing a **behavioral intention**; and finally ending up with a specific **behavior**, which represents the final action (Fishbein & Ajzen, 1975). In an effort to include the cultural perspective, which for some authors is clearer in the TRA, Jane Poss (2001) proposes a model combining the aspects of HBM and the TRA that highlight the normative component of the behavior. Applying these concepts to the Hispanic population and its relationship with the decision-making process, there is a clear connection between the cultural background and the tendency of using one healthcare service over another.

Acculturation/Assimilation

Since one's culture plays a key role in the decision-making process, it is important to mention that in general minority groups that arrive in the U.S. experience a process called acculturation, a term largely studied to explain how immigrants adapt to their new homes. To better understand this term, Amelia Siatkowski (2007) defines acculturation as

> a multidimensional concept involving the interaction between two cultures and the process of change that occurs as a result of the interaction. Through the process of acculturation, an individual learns to adapt by integrating some of the beliefs and values of the new culture, while maintaining some of the beliefs and values of the original culture (p. 322).

This is a key concept for this research, since the Latino population in the U.S., or at least a good number of them, have experienced some degree of acculturation.

There is an agreement among scholars that Hispanics with lower levels of acculturation are less likely to have health insurance and more likely to have a lower economic status than

those with higher levels of acculturation (Perez, 2014; Siatkowski, 2007; Vaeth and Willett, 2005). At the same time, these same authors also agree on one interesting point: higher levels of acculturation are related to negative health outcomes, such as fat intake, obesity, and also smoking. Of course, the health insurance index (likelihood of having insurance) also increases with higher levels of acculturation, but individuals who participated in this body of research have reported that they suffer greater health issues. In regards to learning a new culture, another key component of this process is **assimilation**, in which the newcomers acquire the elements of their new culture, but also how the new culture assimilates to the presence of these new individuals. Different research has shown that, in some cases, full assimilation does not happen until the second or even third generation of descendants starts to emerge (Brown & Bean, 2006).

These concepts and processes can be related to the data on Latinos living in Minnesota. Nearly 26% of Hispanics residing in Minnesota do not have health insurance (Pew Research Center, 2014). This percentage is higher than the national data of uninsured individuals of this same group, which was of 16% by 2015 (U.S. Census, 2016). According to the notion of acculturation previously discussed, if higher levels of acculturation are related to higher access to health insurance, then there is a continuum ranging from those that do not understand the system and do not access health insurance to those that understand the system and can make informed choices on health care services and insurance. Among the 26% of uninsured Latinos living in Minnesota, there is likely a considerable segment who are not fully acculturated, meaning that in general they do not understand the healthcare process very well, and they face significant language and other barriers in accessing services. To provide further context, 60% of Hispanics living in Minnesota are U.S.-born, while 40% are foreign born. It is not surprising, therefore, that 50% of those foreign-born Hispanics are uninsured (Pew Research Center, 2014). As such, this

leaves a huge segment of the population who are potential targets for healthcare communicators seeking to expand their Latino clientele.

Studies about different ethnic groups and their processes of acculturation find that another way to measure the level of acculturation is language (Deyo et al., 1985; Schuman, 1986; Yi, 1995). The Pew Research Center (2014) reports that 63% of Hispanics in Minnesota still speak a language other than English at home. Morales et al. (1999) point out that Latino clients tend to be more satisfied with the communication from healthcare providers when they have greater English proficiency--therefore satisfaction with communication and proficiency in English move in parallel directions. This research concludes that Spanish-speaking Latinos are more dissatisfied with the communication used by health providers than English-speakers Latinos and White Americans, even when having an interpreter with them. This supports what was previously explored: language is an important element of cultural assimilation, but it is not the only thing to take into account when communicating with non-English speakers populations. Hence, this is why it is important to consider what Schutt & Mejía (2016) mention about this topic: "differences in health care satisfaction can alter patterns of health care utilization and so affect health outcomes" (p. 1). In summary, translation of healthcare and communications materials into Spanish is not sufficient in reaching the needs of Latino communities--the process of effectively communicating with this population involves understanding their beliefs, attitudes, and perceptions. These concepts were exposed by Anne Fadiman in her book *The Spirit Catches You and You Fall Down*, where obviously barriers and oversights of language, religion, cultural practices, and cultural competence from the U.S. doctors' side had serious health consequences to the patient and the family and also considered as important components in the Health Belief Model and the Theory of Reasoned Action.

In this regard, researchers have studied the term satisfaction in respect to health care. Wallace et al. (2008) concluded in their study that Hispanics with more English proficiency demonstrate more autonomy in the decision-making process about their own healthcare than those who identified themselves as Spanish speakers; “English responders were still significantly more likely to report positively about aspects of communication dynamics with healthcare providers than Spanish responders” (p. 455). This research also shows that English-speaking Hispanics were more satisfied with the services they received and they were more likely to report positive interactions with their healthcare providers. Spanish speakers were more likely to be dissatisfied and felt disconnected from their providers. Even when Wallace et al. (2008) focus mostly on language, they also pointed out that the higher the income and the higher the level of education, the better chances to ask for information in English and, in consequence, the better outcome in terms of their interaction with healthcare providers; “In most cases, it was the Spanish speakers who reported more difficulty with health care interactions and decision-making autonomy” (p. 456-457). Morales et al. (1999) conclude that Latinos with just Spanish proficiency are more dissatisfied with healthcare providers’ communication than Latinos that speak more English and than non-Latino whites. English-speaking Latinos rate better in satisfaction, but not to the same extent as white participants, who are for the most part satisfied with the communication from healthcare providers (p. 413). Interestingly enough, the authors highlight that English-speaking Latinos do not face the language barrier (as Spanish-speaking Latinos do), but they may face more cultural barriers in comparison with non-Latino whites (p. 410). These results refer back to the concept of acculturation, explored earlier in this literature review and the notion that the more a person has acculturated to the U.S., and the better their English competencies, the greater their access to and satisfaction with healthcare provision.

Method

The main aim of this study is to evaluate the quality and effectiveness of healthcare providers' communication with the Latino community in the Twin Cities through focus group discussions. The research approach is to gather participants' perspectives, attitudes, and opinions about communication materials after allowing the opportunity to review and digest the materials. Two focus groups were conducted: one with 12 participants and a second with eight.

The women in the first focus group were recruited from a nutrition class held at a community center in Minneapolis. The participants were part of a Supplemental Nutrition Assistance Program-Education (SNAP-Ed) class that met five times prior to the focus group discussion. All women were adult mothers from low-income families, foreign-born immigrants; and the majority of them (with the exception of one woman) have US-born children. To understand some of the reasons why participants attend these types of nutrition classes, Garcia-Huidobro et al. (2016) conducted a study of such community-based health interventions for Latino immigrant families. Their research findings explain how, from the cultural perspective, Latino men in general see themselves as providers for their families (they work, they bring economic resources to their homes), while women primarily take care of their households and children. Health-related care for family and children are part of these homemaking tasks culturally assumed as women's responsibilities. To exemplify these gendered responsibilities, Garcia-Huidobro et al. cited what one of the interviewees in their research said, "Many fathers tell women: 'You go (to the class), because you are the mother, you are the one in charge of raising the kids. I am the provider, I only bring money so nothing is missing at home" (p. 64). Researchers used this quote as an example of how, in some occasions, traditional concepts predominate in a large number of Latino families. Gender roles in the Latino community are not

the primary focus of this thesis, but they are important contextually in explaining why Latina women tend to be more involved than Latino men in health-related activities for their families, such as nutrition classes and even deciding what health services and providers should be used. Wittmann-Price (2004) studied women's processes of decision-making on healthcare issues, and stated that "decision-making for women is a significant nursing concern as women make the majority of healthcare decisions for themselves and family members" (p. 438).

A second focus group discussion was conducted subsequently with another group of mothers. Like the first group, these mothers belong to families that qualify as low-income, however the main sociocultural difference was that either they or their husbands were graduate students, thus their low-income status is likely to be temporary while they are students but they will have more economic and social mobility once they have completed their degrees. All of these Latina moms have US-born children and are either recipients of social services such as WIC (Women, Infant, and Children) or SNAP (Supplemental Nutrition Assistance Program), formerly known as food stamps. Eight participants were in this focus group. In order to promote a more in-depth discussion during the analysis of printed materials, participants were divided into smaller groups (three to four per group). First, small groups were given a batch of flyers with the same printed materials to discuss, and each group took notes on their conversations. Then, the women came back together into the larger group to talk about the ideas discussed in the smaller groups. Participants received a $25 gift card from a local supermarket as an incentive for voluntarily attending the focus group discussion.

Measures

Language and translation. As it has been mentioned in the literature review, translation of materials from English to Spanish is one of the most commonly used ways that

healthcare providers attempt to reach Latino communities and promote access to their services. Most of the major clinics, hospitals, and other healthcare providers in the Twin Cities that serve Latinos have translated their communications materials to make their services available for Spanish-speaking individuals. In the focus group discussion guide there was one question asking if the Spanish used in the materials, either in the printed text, website, or video, was clear and understandable. The intention of this question was to identify whether the Spanish used was accessible or, on the contrary, if it was creating another barrier between healthcare providers and participants. The participants discussed whether or not the Spanish was appropriate and sufficient in helping them understand what services were being provided.

Representation. Since language/text is not the only component of communication materials, the focus group discussion also had a separate question asking if they felt they were represented in, and could relate, the Latinos portrayed in the materials. For the use of this study, representation is tied to cultural competence, since it is encompassing ethnicity, socioeconomic status, and also cultural values (family composition, gender roles, different ways of using and/or engaging with the services offered). In this regard, the focus group participants evaluated if there were references to the Latino community in the communication materials, beyond the use of Spanish. The question for discussion said, "Do you feel represented in, and by, the images and words in the content? Why? Why not?"

Attitudes towards information/services. The question "Is the information relevant to you and your needs? Why? Why not?" was at the same time trying to measure attitudes towards the service offered. Namely it was trying to gauge whether the materials motivated participants to seek more information about, or use, the services offered in the communication materials. As well as the representation measurement, this section would provide an idea about

how cultural competent an institution is trying to be. After the discussion, the women were asked, “how likely would you be to use the services of any of these hospitals and clinics? Why? Why not?” In the case of the printed materials, namely the brochures, handouts, and invitations to health-related events and learning opportunities, the question solicited whether they would take the printed product to peruse the information. For the promotional video from a local hospital on maternal health services, the question gathered whether or not they would consider this provider for maternal care.

There was also a question about how to make the information more appealing (“What could you do to make these materials more understandable to all Spanish speakers?”). The objective was to explore if there were ways to improve the content and better tailor it to the intended audience. In this specific point, the responses gave an approximate indication of how to improve the content, but cannot be considered as conclusive due to the limited sample and demographics in these focus groups. However, because the responses started to reach a saturation point where the suggestions began to align across the two groups, the findings are considered qualitatively to be useful and relevant for the intent of this research.

Preferred communication used. The last part series of three questions explored the preferred means of communication for obtaining information about healthcare services or providers. In this section, the first question asked was, “At present, how do you get information about health care services and providers?” Since the answers for this question could potentially generate more than one mode of communication (printed materials, Internet, social media, etc.), the next question was, “What is your preferred way to receive information about health services and providers?” Opinions gathered in this section served as recommendations for which forms of communication materials were most useful and effective, and how they should be disseminated.

Findings

Visual Representation/Imagery

Participants criticized materials when the pictures, or illustrations, used did not correspond and align with the text. There was a general feeling that the photos, often times, were there just to take up space, but that they did not exactly complement or enhance the text. “The text sometimes does not match the photo,” expressed one woman in the first focus group. Another general observation related to how attractive/appealing the materials were to the audience was: “The information is good, but it lacks colors. If I see it, I will not pay attention to it because it is not attractive. If something catches your attention at first, then you wonder ‘what’s that about?’ and you take it.” In general, participants criticized brochures where text was predominant and took up most of the space. They seem to value the content, but they suggested and preferred designs that combined images, colors, and text to make content more understandable and digestible. “The one [brochure] from the state [MNSure] is the best material. It has colors, there is not much text, and the information is separated,” said one participant. Another added, “The information is separated by colors, so it is divided, and your mind can focus on one thing at a time.” Most mothers (in both focus groups) agreed with this idea, and pointed out that when they see a lot of text in some of these materials, they do not take them or do not pay attention to them, even though they recognize that the information might be relevant. “I like the MNSure one because is direct, gets to the point, has colors, and it’s very well organized,” concluded one of the respondents. This is not to suggest that preference for less text is an exclusive cultural characteristic of the Latino community, as preference of images over text can be noted across communications research and populations, but this observation was an important topic of discussion and has such been included in this analysis.

It was also clear through these discussions that the participants already recognized the institutions, such as the hospitals, clinics, and insurance agencies, providing the healthcare services they were reviewing. That was the case with WIC, for example. The WIC brochure was well designed, according to their comments, but the logo was not visible on the first page. Once they realized that WIC was sponsoring this promotional brochure, they criticized the fact that it was not clear which institution was disseminating the brochure from the beginning, and they therefore recommended that healthcare institutions identified themselves transparently on the front page so potential clients know where it is coming from. For these Latino mothers, the brand was an important element in considering whether or on not to use these services, and institutions should clearly brand their services. “I think they should include the WIC logo on the front, because you see the pamphlet and you don’t know who is soliciting you to participate in their programs,” expressed one woman already had knowledge about this specific provider.

Including the brand, logo and name, on the first page or at the beginning of the communication platform was important for helping audiences understand where the information was coming from, but the other reason was to generate trust among the target population. “I’m interested in this brochure because I think the information is important, but I don’t know if I would take it because it does not say where it is coming from,” was one of the opinions regarding this topic. It is important for institutions to identify themselves transparently in their communication with the Latino community as part of the initial engagement process.

Cultural Representation and Values

Representation of the family. One of the main complaints in both focus groups was that in almost all of the printed materials (text and photo), and the video, the image of a mother(s) and her children were represented as the targets. Most of the participants understood why this

was the case, since they acknowledged that mothers are typically the ones who have more contact with these materials and healthcare decision making, but both groups agreed that the concept of family used was limited, especially in the printed documents. “Most of the things we have seen are pictures of mothers and kids, but where are the men? I would like to see more families, because it looks that it [health care services] is just a matter for women.” For this segment of population, the presence of family seems to be important, but they questioned the way gender roles were being perpetuated. In both focus groups, all the respondents were coming from two-family households (none of them were single mothers), where a male figure was present at home. “I do not see the men in some pictures. Some of them have families, but in general it looks like men are not present,” one woman added to the conversation. They agreed on having mothers and children in brochures from WIC, since that institution serves specifically women and their children, but they questioned why the other agencies did not do more to encourage the participation of fathers in the health of their families through the language and images used in their materials.

Another family-related issue brought up when participants were talking about advertising was the extra services that are being offered by healthcare providers to attract participants. The first focus group agreed that childcare was a very important feature that would be a deal maker or breaker for them when considering whether or not to participate in different healthcare sponsored activities. “Sometimes clinics organize workshops or other activities that I would like to attend because I think they are important, but I cannot make it because I have to take care of my children. If they announce that they will have childcare, I might consider going,” was one of the opinions expressed. In regards to the discussion around childcare, it was clear that Latino families are generally interested in getting engaged in many of the activities promoted by clinics,

hospitals, community centers, etc., and these events are indeed a way for healthcare providers to form better relationships with Hispanic families, but this linkage may not happen when variables such as childcare are not considered in the design and planning of such activities. It was noted that some institutions offered food as an incentive to attract participants to their health-related activities, but it was unanimous that offering food is good, but not necessarily the main motivation for attending events of this nature. Childcare, on the other hand, is seen as a vital need in this community. “Instead of offering food, they should better offer childcare. If I am interested in the information, I would go regardless of whether they give food or not. Meanwhile, I would not definitely go if there is not childcare,” expressed one mother.

How well the family was considered in the design of materials was connected to the issue of how well represented participants thought the Latino community was in the communications materials analyzed; findings were generated through the question, *Do you feel represented in these materials?* Responses started out by discussing the type of Spanish used (which will be treated more in depth in the next section), but even when the text was in Spanish respondents did not necessarily feel represented when the people in the pictured did not look Latino. One participant mentioned, “There are no Latinos in these pictures, the people do not look like us.” She was referring to a website with recommendations in Spanish for what to do to practice weight lifting. In the picture accompanying the article, there were two men: one White and one African-American. The information was interesting and very well written, but most mothers did not find any value for them and/or their children in knowing about weight lifting. While Latinos can indeed be light skinned (White) or African-American, the absence of more brown-skinned Latinos suggested that the models in the photos were not Latinos. As the majority of the Latinos

living in the Twin Cities are Mexican or Ecuadorian, with smaller populations of light-skinned and Afro-Latinos, they did not necessarily relate racially to the photos.

There was another family-related topic that brought questions up and put another discussion on the table, the "doula." After watching a video from one local hospital, participants started asking what a doula is. Some of the mothers who had lived longer in the U.S. explained to the rest of the group what a doula is. One of them even contextualized the doula by link the concept socioculturally to what is commonplace in the Latino community, "In our culture, we have our mothers, a close friend, or a sister helping us during the delivery. Having a doula seems to be something good, but at the beginning it is difficult to understand [their role] because we are not used to this." Some mothers expressed that they never heard this term before. Once someone in the room explained what a doula was, they were interested in getting more information regarding this services, but simply translating/using the term without contextualizing the concept within the culture of Latinos was lost on a good number of participants.

Language. Participants in general gave credit to healthcare institutions for making the effort to offer information in Spanish, or when they provided a telephone line for Spanish-speaker participants, but at the same time there was a perception that the waiting time for these lines was longer than if they just chose to wait for the customer service in English. "The problem is that when you pick the Spanish line, they make you wait for a long time, more time than if you wait for the person who speaks to you in English," said one of the respondents. In this specific point, at least five more participants in the first focus group agreed, "Sometimes I have waited more than 30 minutes," contributed another mother. In the second focus group, this topic also came up. The difference with this second group was that in general the participant's English proficiency was higher than with the participants in the first focus group. "We wait longer in the

line for Spanish, that is why sometimes I prefer to do it in English," stated one participant from the second group. As it was explained before with the literature by Morales et al. (2009) and Wallace et al. (2008), language proficiency is a factor in how one rates their satisfaction with healthcare services. Level of proficiency also plays into the process of acculturation, having influence on the way immigrants access services and how they interact with their new environment; the higher their proficiency the more options and services they can access and the more satisfied they tend to be.

Especially in the second focus group, with the women that have some university-level education, one important issue they identified was the difference between "proper" Spanish [meaning commonplace and technically correct in Spanish] versus "translated" Spanish [which translates English word-for-for without contextualizing]. The topic came up in the conversation because the materials used the term "champion," which in English can refer to someone with mastery of some skill or knowledge and/or leadership aptitudes. In the Spanish version analyzed in the focus group, the translated term used was "campeón", which does not have the same meaning or use in Spanish; *campeón* only means the winner of a race or competition and does not have this double meaning that the English word has. "I read that headline and I don't understand. It is obvious that they have literally translated the word "champion,' but I read it and it does not make any sense to me in Spanish," said one participant. In this focus group, at least four communications materials were found using direct translations from English to Spanish, without interpreting and considering what would be the best term to use in Spanish.

Another issue with healthcare information is the medical vocabulary implemented to offer benefits and/or services. Perez (2014) incorporated in her study the term "health literacy," which refers to an individual's ability to understand information on healthcare services and

benefits. In both focus groups, health literacy came up in the discussions about the communications materials analyzed. Participants agreed that the vocabulary used by healthcare institutions is often complicated. “They should use more common words,” respondents recommended. Additionally, participants said that sometimes they have trouble interpreting acronyms. In Spanish the use of acronyms exists, but not in the same extent as in English. There were some participants in the first focus group that did not know what LGBTQ means. In this specific case, participants recognized that using the rainbow (pride) flag would be more universal than the acronym, but they also presented the option of clarifying what acronyms stand for. Other terms that came to play were MRI (Magnetic Resonance Imaging), CT Scan (Computed Tomography Scan), DOB (Date of Birth), etc., often found in promotional materials from healthcare institution, and which are not necessarily translated into Spanish and means that a good number of readers may not understand what they mean.

The less text the better (less is more). Materials with smaller amounts and clustering of text solicited more favorable responses overall than those that were text-heavy. The brochures with the most positive feedback were one from MNSure and one from WIC. These materials had a very simple design, few words, and they were offering really useful resources for low-income populations in a way that respected the demographics and backgrounds of the individuals and that represented their families respectfully (included men in the family photos and had people that looked like the majority of the Latinos in the focus groups). While it was clear that the services were for people from low-income backgrounds, the institutions did not highlight or accentuate or tokenize their poverty in the content. There were also references on how to contact these institutions for further consultations in English and Spanish, so both groups were pleased with the elements included in the design.

For both focus groups, communication materials with solely words yielded more negative response. Again, participants said that the information seemed to be important, but they did not have time or interest when they saw the mass of text. There were exceptions, however, and participants acknowledged that in some print communications text is necessary. One mother from the second focus group explained, “There are people that are better with words and others that don’t want to read because they are better with pictures or graphics.” She was in part referring to visualization preferences, but she was also alluding to different literacy levels among the participants. It was clear that some of the materials were better suited to audiences with higher literacy levels and some brochures that tried to communicate information to readers with varying literacy levels. To address this dilemma of amount and level of language, participants recommended creating a more visual version with short explanatory sentences and larger pictures or drawings evoking what they wanted clients to understand and gain from the materials.

Socioeconomic labels and representation. Low-income families are aware of their socioeconomic situations. There was a sense in the focus groups that they do not want to be reminded about their situation through communication materials from the same institutions offering them services. In one of the brochures there was a headline saying, “Poverty of nobody,” to which participants reacted with an uncomfortable feeling that they were being labeled in a negative way. Some of the respondents even suggested rephrasing this concept using more positive words, such as “Opportunities for everybody.” “It [the phrase ‘poverty of nobody’ sounds morally degrading, it makes you feel small. After seeing that word [poverty], I don’t know if I want to go [to this event/service].” Another participant added, “Why do they have to call me poor. I might be poor, but I feel good emotionally, and maybe them calling us that makes people feel bad.” The opinions regarding this point were stronger in the first focus group than in

the second one, in which participants are likely temporarily low-income and have the education levels to obtain better jobs and change their socioeconomic status when they have completed their schooling.

Access to Information and Attitudes

Internet and the word-of-mouth. When participants need health services, they mention several options for obtaining this information. The first focus group leaned more towards Internet searches, while for the second focus group email correspondence seemed to be more accepted as a mode of learning about services. This difference is likely related to the way both groups access their health insurance: while in the first group the majority look for affordable care, sometimes free services, the second group of participants were more likely to be insured through students' services at the University of Minnesota. As such, they are subscribed to an email server where they get information directly that their addresses their needs. Further research should be conducted to better understand this specific topic on how to best convey healthcare information for the different segments of the population. Even when Internet search and email were mentioned as one of the first contacts with the health system in Minnesota, both groups agreed that word-of-mouth was the most important influencer in the decision-making process about where to go or even what services to get. "I had a bad experience in one hospital, so I gathered information with some of my friends and I ended up in a good hospital," one mentioned.

The women who were participating in the focus groups have used a diverse range of health services either for themselves or for their children. The ones who have been more time in Minneapolis/St. Paul know better where to go, depending on their situations, than the newer immigrants, and speak with authority when emitting an opinion about what hospitals offer better

benefits in respect to others. This situation brings the concept of acculturation back into the discussion, since it seems that people with more knowledge of the system have better results in using healthcare services than those that do not know the environment well. One important thing to consider is that family support is a key component for those that are new to this geographic area or do not have enough English skills. Relatives that have lived in Minneapolis/St. Paul often serve as interpreters for members of the family with low English proficiency levels. So, for example, when creating communications materials, family members (extended and immediate) should be taken into consideration in the images/texts/contexts in order to better reflect the realities of the Latino audience. In this regard, it is important to realize that the community and extended-family support is a key element for newcomers in identifying the health services they need.

Related to word-of-mouth notion, there was another element during the conversation in the focus groups that brought the discussion back to the amount of text in materials. While brochures are still one of the preferred ways of getting information, according to most of the respondents this form of communication tends to have too much text and too little images. The challenge here is for the communicators to learn how to prioritize relevant information for the target community. “There are people that do not like to read, so for those we should have a brochure with less words and more pictures,” suggested one mother. But for those occasions when text dominates and it is difficult to avoid text, one of the participants mentioned while grabbing one of the brochures that was text-heavy, “I think all the information here is relevant, but I had some confusion about what they [the healthcare provider] is offering. I think this material has to be shared by someone that is going to explain to you the brochure and its information.” This specific participant introduced the concept of having a representative from

these institutions share this textual information with the community through the word-of-mouth style a *promotor de salud* would use. A *promotor de salud* is a type of social worker who speaks Spanish and who works shifts in some clinics and hospitals to inform the Latino community about services available—they combine oral and text information. According to the perception of the participants in the focus groups, these *promotores* are not always sync with doctors, nurses, and interpreters, but when they are present clients are generally more satisfied. While providing *promotores* may pose a cost to the institution, or some-level of coordination in the case these *promotores* are volunteers, it provides an important opportunity for communications departments in health institutions that want to implement cultural competence in their marketing and communication processes. These *promotores de salud* are usually seen as trustworthy, not just because they speak Spanish, but because they provide the information people need in the moment they need it. Some social workers already make these kinds of connection, liking services to potential clients, but it is also something to be considered from the communications perspective, since the idea is to offer services in an appropriate manner for the Latino community. This solution integrates communication materials with cultural components that make information more suitable and tailored to the needs of the target population.

Video as a communication material. Both focus groups watched a video produced by a local county hospital promoting its birth center. The content was well received in both focus groups. In terms of favorable attitudes towards the service, people were in general willing to use the information provided. The narrator was speaking in a clear and neutral Spanish, according to the focus groups, but some participants pointed out that there were fragments where it seemed to them that there was a direct translation from an original text written in English. The audio at the end of the video invited viewers to take a tour at the hospital so potential clients could see more

in depth what was being offered in the video. “I feel motivated for taking the tour, because I see some interesting things, but I probably would like to ask some questions on-site,” was one of the comments. One participant, when she saw a positive reaction towards the video among the other participants, clarified: “I think the video is good, but I know that hospital and I can tell [you] that some things are not accurate. Some services are not offered anymore, but you would not know that if you don’t go.” In this case, her experience in this institution served as a contrast to what the video was presenting to the clients. As it was mentioned, experience and word-of-mouth is an important element to consider, but most importantly, content and actual services offered need to be aligned on the same page; videos that present services that are no longer offered are not transparent and honest. In the second focus group, nobody knew by experience about his hospital, so the reactions were positive towards the respectful language used and the services offered. Women also said they felt motivated to at least take the tour.

Phones, social media, and privacy issues. At least with these two focus groups, when asking directly if text messages would be an option for getting information about health services, reactions were not positive. “There is a privacy issue. I gave my number out for information once, and I started getting offers for other things that I did not sign up for. It looks like companies share your information and you start receiving a lot of things you don’t want,” was the reasoning of one participant. The same response was observed in the second focus group. Text messages are perceived as invasive if the receivers did not agree to receive these correspondences. People in these two focus groups showed more interest in looking online for services they needed, or going directly to the hospital or clinic to ask for more details in person; “For me is better to go to the clinic and ask there. Now it’s easier to get information in Spanish than 15 years ago.” This illustrates what Fishbein and Ajzen (1975) explained in the Reasoned

Action Theory, specifically about the *perceived behavioral control* phase, in which clients evaluate how much control they have over their decisions. There was a sense of autonomy when talking about looking for services. Participants did not like the experience of being chased by the institutions in an invasive way. They preferred to reach out to them when they needed them, versus the other way around.

Especially in the second focus group, social media was more accepted than in the first focus group. But in general, both groups agreed in using social media to obtain information about healthcare services if they signed up for this information. These particular participants used Facebook more than Instagram or Twitter. They expressed interest in, for example, liking a page in Facebook so they can keep themselves informed about what a clinic, hospital or other institution providing health services are doing.

In summary, while language (and translation issues) was criticized during the focus groups, it was not the only aspect participants focused on. They also mentioned other aspects of being both Latinos and immigrants in the U.S. to be taken into consideration when healthcare providers or institutions are trying to communicate with them. These included resisting being labeled by socioeconomic status (i.e. poor Latino immigrants), seeing healthcare as a family issue not a woman's issue, (i.e. *familismo*), and valuing more images and less text.

Discussion

The results from these two focus groups suggest that the Latino community, even while they value having information from healthcare providers in Spanish, recognize when communications materials are just being directly translated from English, which can cause misunderstandings when the translated terminology does not correspond with the right interpretation in Spanish. Language has been identified as a crucial element in the outreach process for the Latino community and in soliciting favorable attitudes toward healthcare services as well as use of services (Deyo et. al., 1985; Wallace et. al., 2008). However, language is just one component of culture, there are also other factors to consider when creating communication campaigns for this community. One such factor relates to the concept of family, or what it is called the value of *familismo* in several research studies related to health issues among Hispanics. The notion *familismo* encompasses the strong ties that Latinos usually have with their extended family, not just their immediate or nuclear families as in many U.S. contexts (Ayon, Marsiglia, & Bermudez, 2010). It has been found that the value of *familismo* influences the decision-making process among Hispanics. Family is generally the first connection for newcomers, and it is often the first orientation new immigrants have to the place they will live in. What their relatives (or even close friends) say and/or recommend is going to be important if someone has to decide what hospital that person should use in case of an emergency, or what doctor they should start consulting. This was mentioned during the focus groups, where participants said that they go where family or friends recommended they go based on previous experiences. To this point, it is worth mentioning that it the process of acculturation has shown to have a vital effect on how Hispanics adopt the healthcare experience and the new system (Hovey, 2000; Brown & Bean 2006; Schumann, 1986). In the focus groups, for example, there

were some participants who recently moved from other states or countries to the Twin Cities, and they said that they rely on what relatives or friends said about where to go not just for health care issues, but for other services too. This *familismo* dynamic goes hand-in-hand with the idea of word-of-mouth communication among Hispanics, which was the preferred mode of communication on healthcare issues. Hospitals and clinics' reputations among this specific community of focus group participants cascades to other communities; their success in attracting this group of potential clients means they have the opportunity to connect with Hispanics users beyond these participants through word-of-mouth references and referrals.

From this perspective, Latinos that have lived longer in the Twin Cities will have a better understanding about how to use the health services around them (although this also intersects with education and literacy levels), while the newcomers will probably struggle more or will generate a word-of-mouth process in order to find those resources. Regarding the acculturation process, the more Latinos assimilate to the U.S. culture from the Twin Cities, the easier it will be for them to navigate the healthcare system (Perez, 2014; Siatkowski, 2007; Vaeth & Willett, 2005). As it was explained before, language acquisition is a factor to consider in the acculturation process, but not the only one. There were participants in the focus groups with low English proficiency, and yet they expressed being confident about knowing what to do or where to go in case they needed health services. The majority of them would go directly to places where they know there is a *promotor de salud* that speaks Spanish. Usually this *promotor de salud* is someone who can explain clearly all the options for the potential clients, in their own language, so they have generate a great deal of trust among the Latino community once people know about them as a resource. Therefore the *promotor de salud* brings together word-of-mouth communication with materials from the providers, as a way of promoting health access among

this specific community. All these cultural elements (such as language, *familismo*, the preference for word-of-mouth communication, etc.) when combined help ensure a level of cultural competence in the process of creating healthcare communications campaigns for the Latino community in the Twin Cities. There has been extensive research on how important it is for doctors, nurses, and other health practitioners to be culturally competent when they deal with Hispanics, as well as other diverse communities and ethnic groups in general (Beamon et al., 2006; Jenakovic, 2001; Rees & Ruiz, 2003; Tseng & Streltzer, 2008), and now it is time to permeate this idea of cultural competence into the communications arena in order to generate messages tailored to the cultural characteristics of the Latino community in this geographic area of the U.S.

The process of acculturation as it relates to attitudes toward healthcare providers, relates back to the *Theory of Reasoned Action* (Fishbein & Ajzen, 1975), in which there are five assumed stages before action is taken: attitude, perceived norms, perceived behavioral control, behavioral intention, and behavior. Each of these stages can be linked to different levels of acculturation in Hispanic clients; for example, many Latinos do not understand the need to purchase monthly health insurance, as it seems like a major unnecessary expense. In their home countries they are used to paying out of pocket or accessing national insurance (perceived norm) and they may take risks because they have not yet experienced a medical crises that has confronted the need to change their behavior. During the focus groups the women explained how they wanted to feel in control of the type of healthcare they procured for their families. They strongly recommended allowing potential clients to decide what are the best options for their families, which suggests that they want to know the information, but at the end they would like to decide what services they are eligible for and/or can afford or access. The Theory of Reasoned

Action is a useful concept for communicators when deciding what is the right moment and strategy to helping Hispanics overcome the many obstacles they face and which may be preventing them from taking advantage of certain services.

Communications Insights

Through the course of this research, a number of critical insights have been learned from the women participants; most of these findings are related to the need for incorporating cultural competence into healthcare providers' processes of communication with the Latino community. The main topics discussed in the focus groups lead to some insights that could be useful for hospitals, clinics, health insurance companies, and other institutions that provide health services to the Latino community in order to generate more participation, and potentially greater satisfaction, in the process of obtaining those services.

Be careful how to label and address clients from low socioeconomic backgrounds. Low-income Latino families and communities are the main focus in this research, and the main target by healthcare institutions providing services to Hispanic populations. While participants in this research, who themselves can be characterized as low-income, reiterate in their responses—they are fully aware of their situation and do not need to be reminded about it through communications materials. Communicators have to be aware that using certain language makes potential clients feel labeled and patronized about their economic situations and compromise or dissuade them the from approaching these very institutions offering them health services. Healthcare institutions should therefore be careful with the language used to refer to these individuals. It is highly recommended to use a positive approach and avoid words that may remind potential clients about their socioeconomic situation. Instead, the language suggested is more inclusive and dignifying.

Add men and *familismo* to the discussion and representation in healthcare materials. While women do often have a key role in the decision-making process in their families in regards to selecting and accessing healthcare providers and services, participants

openly mentioned that men also need to be considered as key targets in healthcare institutions communication with potential clients. This relates to the collective view of the family among the Latino community, or *familismo*. Communications strategies should start breaking the myth that health is a matter just for women and children, and expand communication of services to incorporate both men and extended family.

Add cultural competence to Spanish translations and materials, and reinforce that less text is often more effective. Translation of services into Spanish is good and useful, but often it dos not go far enough in making these materials effective and relevant. Consumers can identify when materials are being just translated from their English versions instead of writing materials in a Spanish that is relevant and appropriate to the context. Therefore efforts need to be made to ensure the materials are culturally competent, and reflective in terms of language as well as context. In regards to the amount of language used, short texts and segmented ideas help Latinos understand the content better. Too much text can dissuade participants from consuming and reading certain materials, which makes it more difficult to deliver the information to the intended audience(s).

Combine cultural competence, word-of-mouth-communication, and written/visual materials. Communicators, as well as health practitioners, have already started to include cultural competence in their efforts to interact with the Latino community—mainly by better understanding their populations and using *promotores de salud*. To accomplish cultural competence, it is necessary to have sensitive and committed communicators, willing to learn about the opportunities brought by immigrant segments of the population. To create messages for immigrant populations it is imperative to be informed about the nuanced circumstances and issues surrounding these groups. Cultural competence it is not necessarily knowing every single

detail of a group's culture, but it means being aware of their needs, and their overarching circumstances and demographics, as a large community living in the Twin Cities.

In addition to being informed about the population, healthcare providers should consider having a *promotor de salud* as a means of providing information on their services to the Latino community. This is not a social worker; it is more like a communicator who has the ability to relate to Hispanics in ways that are culturally and socially relevant to this population. *Promotores* can be used to inform potential clients about services they can access, as well as dispelling certain myths and misunderstandings they may have about the U.S. healthcare system. As the focus groups alluded, Hispanics use word-of-mouth communication to a great extent, so this *promotor de salud/communicator* brings together oral communication with formal materials and information, in ways that are accessible and culturally and social relevant to the key community.

Incorporating cultural competence into communications activities does not necessarily mean dramatically increasing communications-related expenses or budgets for health institutions. Hiring cultural competent staff is something that is already happening in other areas of the healthcare system (doctors, nurses, front desk representatives, on-site interpreters, etc.), and communications team members should also have the skills to integrate cultural competence into the work with diverse populations. It is also highly recommended to build capacity in cultural competence within the institutions internally, in the same way nurses, doctors, and health care providers are trained to work with the varying populations and cultural groups they serve. In the long term, medical expenses could be higher for the U.S. health system if healthcare providers do not allocate money inviting people to use services that could be preventive.

Healthcare communicators are highly encouraged to incorporate cultural competence in their process of creating materials and communication strategies designed for the Latino community. While this document concentrates in one specific ethnic group, cultural competence is a matter of including also other groups, considering that the Twin Cities is one of the most diverse metropolitan areas in the United States. Doing this, communicators could help making the idea of access to healthcare a human right more than a privilege for those that already understand the U.S. system.

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Appendix A: Focus Group Discussion Questions

Latino responses to communications materials

from clinics and hospitals

Thank you for participating in this focus group. My name is Rafael Flores, a Masters in Strategic Communication graduate student at the University of Minnesota. This research is part of the requirements for my studies. You are participating because you are a Latino/a living in the Twin Cities and at some point you have used, or are going to use, health care services for yourself or for members of your family.

I am going to show you some materials from local hospitals and clinics. I would like you to examine these in detail and then tell me what do you think.

Show printed materials such as brochures, posters, trifolds, etc.

1. Is the way the information is presented engaging? Does the information draw you in?
2. What can you tell me about the type of Spanish used? *Probe:* Is it clear and understandable? What parts are confusing?
3. Do you feel represented in, and by, the images and words in the content? Why? Why not?
4. Would you pick up any of these communications materials to look at if you saw them in a waiting room or on a counter? Why? Why not?
5. After seeing these materials, how likely would you be to use the services of any of these hospitals and clinics? Why? Why not?
6. What could you do to make these materials understandable to all Spanish speakers?

Show Internet products (websites with information in Spanish).

6. Is the information relevant to you and the needs of your family? Why? Why not?

7. What parts are clear and easy to follow? What parts are confusing?

8. Would you come back to this site to look for more information? What would make the site more relevant and appealing to you?

Show video.

9. Is the information relevant to you and your needs? Why? Why not?

10. What parts of the information are clear and easy to follow? What parts are confusing?

11. What would make the information more relevant and appealing to you?

Accessing information.

12. At present, how do you get information about health care services and providers?

13. What is your preferred way to receive information about health services and providers?

14. Would your phone (text messages, social media, advertisement) be a good way to get you or your family information regarding health services?

15. If you have a health issue in your family, do you feel confident about what to do or where to go to get services?

Wrap-up Question: Is there anything else about the information I've shown you today that you would like to share?

Thank you for your time and participation!

Appendix B: Communications Materials

Internet:

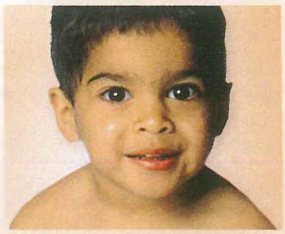
https://www.childrensmn.org/educationmaterials/teens/article/12083/entrenamiento-de-la-fuerza-muscular/

Video:
https://www.youtube.com/watch?v=7OS-AesXPck

¿Conoce usted...

A alguna mujer embarazada?

Alguna familia con niños pequeños a la que le gustaría recibir información sobre consejos de nutrición y alimentos sanos?



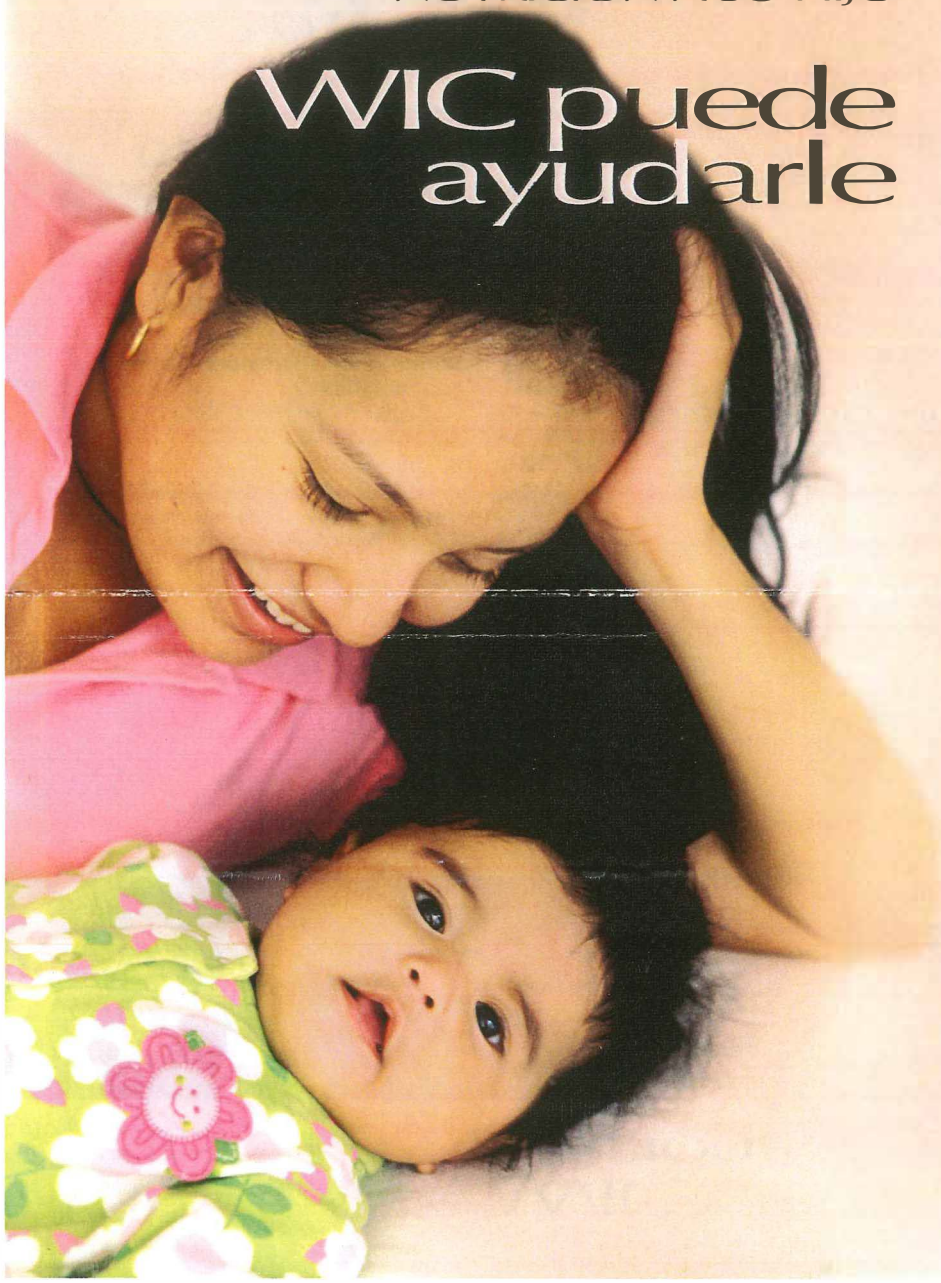
Una familia que trabaja y tiene problemas económicos?

Si contestó "sí" a cualquiera de estas preguntas, deseamos compartir con usted un excelente programa de nutrición.

MINNESOTA WIC
Conexion con Usted
NUTRICIÓN PARA MUJERES, INFANTES Y NIÑOS

PROPORCIÓNELE UNA BUENA NUTRICIÓN A SU HIJO

WIC puede ayudarle



WIC OFRECE...

- Información y consejos sobre nutrición
- Apoyo para la mujer que está amamantando
- Alimentos sanos como frutas y verduras frescas, cereales de granos integrales, pan y tortillas, leche descremada y alimentos para infantes
- Un personal cuidadoso y atento

USTED PODRÍA TENER DERECHO...

- Muchas familias de la clase trabajadora tienen derecho a participar en el programa WIC
- Las familias que reciben Asistencia Médica tienen derecho a participar en WIC
- Usted no necesita ser ciudadano de los Estados Unidos

LLAME HOY MISMO PARA OBTENER INFORMACIÓN SOBRE LA CLÍNICA DE WIC MÁS CERCANA A SU DOMICILIO

1-800-WIC-4030

(O LLAME AL 1-800-942-4030)

También usted puede visitar el sitio web del Departamento de Salud de Minnesota a

www.health.state.mn.us/wic

NO ESPERE...ESTAMOS AQUÍ PARA AYUDARLE

Usted y su hijo

SANOS Y BIEN ALIMENTADOS
EL PROGRAMA WIC PUEDE AYUDARLE

MINNESOTA WIC
Conexion con Usted
NUTRICIÓN PARA MUJERES, INFANTES Y NIÑOS

1-800-WIC-4030
(O LLAME AL 1-800-942-4030)

También usted puede visitar el sitio web del Departamento de Salud de Minnesota a
www.health.state.mn.us/wic

Para solicitar este material en un formato diferente, póngase en contacto con:

MDH Minnesota Department *of* Health

Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882
1-800-657-3942

Esta institución es un proveedor que ofrece igualdad de oportunidade. Impreso en papel reciclado. 6/16 Spanish ID#52746

In Hennepin County call
612-348-6100

USTED O ALGUIEN QUE USTED CONOCE TIENE DERECHO A PARTICIPAR EN EL PROGRAMA WIC...

Comparta este folleto con una amiga o amigo.

WIC funciona...

- Embarazos más sanos
- Partos más sanos
- Niños más sanos

Guía de ingresos

A partir de julio del 2016 y hasta junio del 2017

Guía de Elegibilidad Según los Ingresos de Inscripción en Programas de Cuidado de Salud de Minnesota (como Asistencia Médica+)

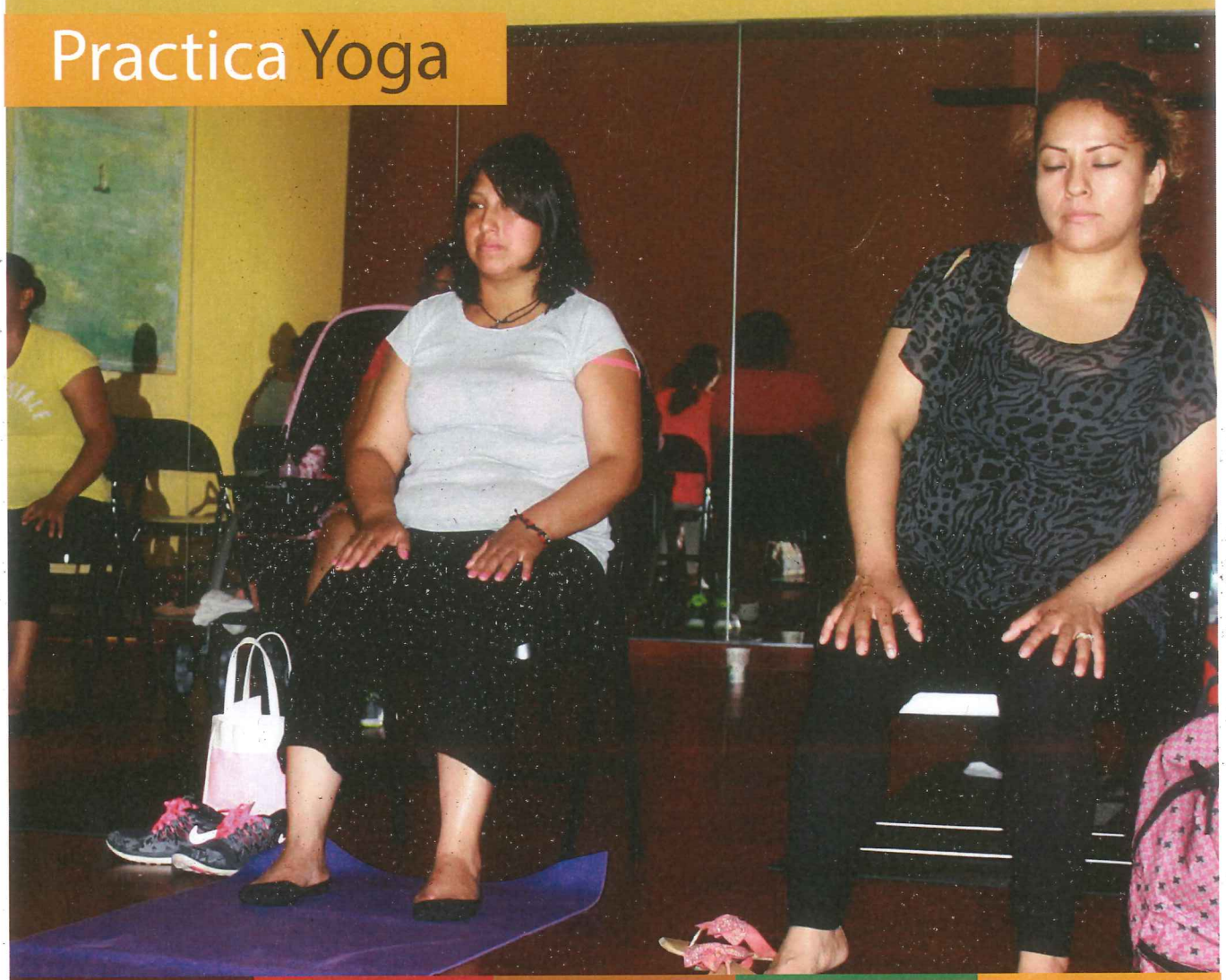
NÚMERO DE MIEMBROS EN LA FAMILIA*	INGRESO BRUTO ANUAL
1	$32,670
2	44,110
3	55,550
4	66,990
5	78,430
6	89,870
7	101,310
8	112,750

Guía de Elegibilidad Estándar Según los Ingresos

NÚMERO DE MIEMBROS EN LA FAMILIA*	INGRESO BRUTO ANUAL
1	$21,978
2	29,637
3	37,296
4	44,955
5	52,614
6	60,273
7	67,951
8	75,647

+ Medicaid (MA)
** Las mujeres embarazadas cuentan por 2 personas*

Practica Yoga



Educación | Bienestar | Recursos

Fortalecerás tu mente y cuerpo. Aprenderás diferentes técnicas de respiración y relajación.

Fecha: Abril 21, Abril 28, Mayo 5 y Mayo 12
Hora: 10:30am a 12:30pm
Lugar: Centro Tyrone Guzman
1915 Chicago Avenue, Minneapolis, MN 55404

CENTRO
TYRONE GUZMAN

Llama al **(612) 874 -1412** y pregunta por **María Padilla**

HABLEMOS de SEXUALIDAD

Aprendamos juntos sobre el desarrollo sexual de nuestros hijos e hijas, y cómo hablar con ellos de la sexualidad.

¡Están invitados(as)!

de 5:00 a 7:00pm

con cena ligera

Adultos
Adultos+hijos
grupos.

20 abril	Conociéndonos	K-1
27 abril	Nuestros Cuerpos	
4 mayo	Etapas del Desarrollo	2-3
11 mayo	Iniciemos la Conversación	

en La Clínica

153 Cesar Chávez Street, St. Paul

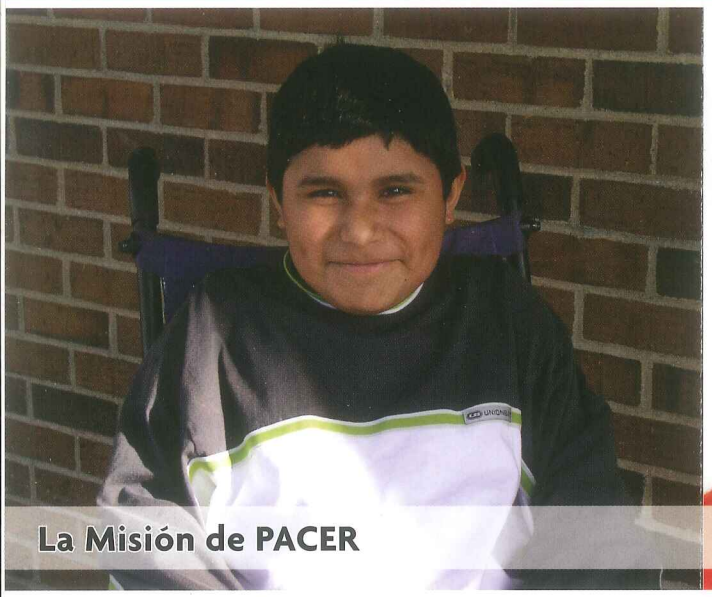
PARA MÁS INFORMACIÓN

llame a Pilar

651.389.2411

CLUES

West Side Community Health Services



La Misión de PACER

PACER mejora la calidad de vida y expande oportunidades para los niños y jóvenes adultos con discapacidades y sus familias para que cada persona pueda lograr su potencial más alto.

SITIOS DE PACER EN EL INTERNET

PACER.org
Información y enlaces para familias

PACER.org/mpc
MN PIRC-Padres participando en la educación

PACERKidsAgainstBullying.org*
PACERTeensAgainstBullying.org*

taalliance.org
Red Nacional de Centros para Padres

FAPE.org
Ley de Educación para Personas con Discapacidades (IDEA)

c3online.org
Recursos para transición y empleo

PACER.org/international
Recursos globales para familias

*Bullying= Cualquier acoso fisico, verbal o psicológico en las escuelas

Acerca de PACER Center

PACER Center es un centro para padres en Minnesota y a nivel nacional. PACER expande oportunidades y mejora la calidad de vida de los niños y jóvenes adultos con discapacidades y sus familias.

Basado en el concepto de padres ayudando a padres, el personal de PACER está compuesto principalmente por padres de niños con discapacidades que entienden sus preocupaciones e inquietudes.

Incorporado en 1977, PACER es una organización sin fines de lucro que trabaja con 18 grupos de discapacidades.

PACER CENTER
CAMPEONES DE NIÑOS CON DISCAPACIDADES™

8161 NORMANDALE BLVD. | MINNEAPOLIS, MN 55437
952.838.9000 VOZ | 952.838.0190 TTY
952.838.0199 FAX
800.53.PACER LÍNEA GRATUITA EN MINNESOTA
PACER@PACER.ORG | **PACER.ORG**

PAULA F. GOLDBERG, DIRECTORA EJECUTIVA

MARY SCHROCK, EJECUTIVA DE OPERACIONES Y DESARROLLO

PACER recibe fondos del gobierno, fundaciones y recursos privados.

PACER CENTER
CAMPEONES DE NIÑOS CON DISCAPACIDADES™

53

Su lugar de información, entrenamiento y apoyo para las familias de niños con discapacidades y para la participación entre padres y escuelas.

PACER.org | 952.838.9000 | PACER@PACER.org

Proyecto de Niñez Temprana

PACER AYUDA A PADRES Y A PROFESIONALES

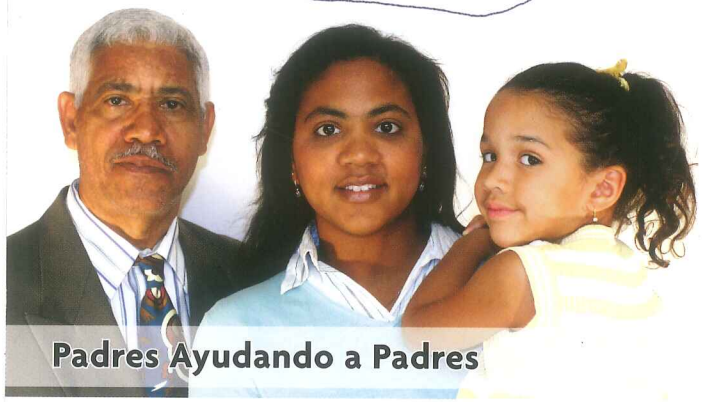
PACER AYUDA DE MUCHAS MANERAS

A través de más de 30 proyectos, PACER proporciona asistencia individual, talleres, publicaciones y otros recursos para ayudar a las familias a tomar decisiones acerca de la educación y otros servicios para sus niños y jóvenes adultos con discapacidades.

El Centro para Padres de Minnesota de PACER –MN PIRC- proporciona recursos para incrementar la participación de todos los padres en la educación de sus hijos.

PACER ES PARA:

- Familias y sus niños o jóvenes adultos con discapacidades o con necesidades de cuidado especial de salud desde el nacimiento hasta la mayoría de edad.
- Maestros y otros profesionales que trabajan con estudiantes con y sin discapacidades.
- Padres de todo tipo de niños y escuelas trabajando juntos para fomentar la participación de la familia en la educación.



Padres Ayudando a Padres

Recursos para Jóvenes Adultos

Servicios Multiculturales

APRENDA MÁS ACERCA DE PACER

¿CÓMO EMPIEZO?

Llame a PACER al 952.838.9000
Las horas de oficina son de 8 a.m. a 5 p.m. (TC)
O en el Internet en PACER.org
Mande un correo electrónico a PACER@PACER.org
Síganos en facebook, youtube y Twitter

¿QUÉ PUEDO YO ESPERAR?

Contactando a PACER usted está tomando el primer paso hacia la obtención de más apoyo para su familia.

La mayoría del personal de PACER son padres de niños con discapacidades y por lo tanto entienden lo que usted está experimentando y están listos para ayudarle a usted a ayudar a su hijo/a.

¿CÓMO ME PUEDE AYUDAR PACER?

El personal de PACER le ayudará a encontrar los recursos o la información que usted necesite.

PACER ayuda a una gran variedad de familias y profesionales a nivel local, estatal y nacional todos los días. La mayoría de los servicios de PACER se proporcionan en forma gratuita para las familias en Minnesota.

¿Quién está en el equipo de cuidado?

u equipo siempre lo integrarán
STED, su médico o enfermera
racticante y un Trabajador Social de
. Comunidad. Otros miembros del
quipo de cuidado pueden incluir:

Coordinador de enfermeras tituladas

Trabajador social

Farmacéutico

Asistente médico del equipo

Otro personal de apoyo clínico de bienvenida

Información de la clínica:

Mi proveedor de atención médica es:

_____

Mi trabajadora de salud de la comunidad es:

_____

Otros miembros del equipo están disponibles:

_____

Llame a la clínica al 612-873-6963:

- Durante los días de semana y los fines de semana para hacer una cita o hablar con una enfermera de triage.
- Las **24 horas del día** si tiene que hablar con un proveedor de guardia.

Whittier Clinic
Hennepin County **Medical Center**

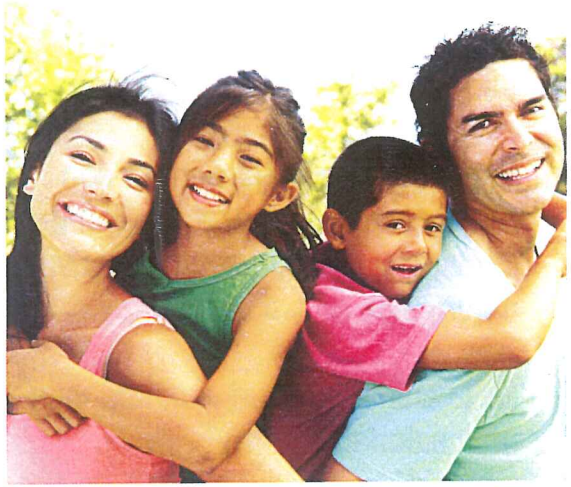
Whittier Clinic Health Care Home
2810 Nicollet Ave
Minneapolis, MN 55408

12/13

Hogar de cuidado de la salud

(Health Care Home - Spanish)

La Clínica Whittier



Una manera de proporcionar atención médica coordinada y centrada en el paciente y su familia.

Whittier Clinic
Hennepin County **Medical Center**

¿Qué es el hogar para el cuidado de la salud de la Clínica Whittier?

- Un hogar para el cuidado de la salud es un equipo de personas, conducido por un proveedor de atención médica, que trabajará con usted para ayudarle a administrar su salud.

- Este equipo trabajará junto con usted para desarrollar un plan de cuidado que incluye sus objetivos personales de salud.

- Se le alentará a que viva una vida más saludable a través de la educación, apoyo en curso de sus miembros del equipo y el uso apropiado de los medicamentos y que logre sus objetivos de salud.

¿Cómo me puede ayudar el hogar para el cuidado de la salud de la Clínica Whittier?

El hogar para el cuidado de la salud de la Clínica Whittier lo puede ayudar:

- Trabajando con usted para desarrollar un plan de cuidado personal

- Brindándole apoyo y ánimo para lograr sus metas

- Conectándolo con recursos y programas comunitarios

- Ayudándolo con sus inquietudes financieras y papeleo

- Recordándole sus próximas citas y exámenes

¿Cómo me puedo unir a un hogar de cuidado de la salud?

¡Unirse a un hogar de cuidado de la salud es fácil!

Paso 1: Informe a su proveedor que quiere más información sobre un hogar de cuidado de la salud.

Paso 2: Su trabajador social de la comunidad coordinará con usted para programar una reunión con equipo de cuidado, conducida po su proveedor.

Paso 3: En esta reunión, usted y su equipo de cuidado hablarán sobre maneras de mejorar su salud. Juntos establecerán los objetivos para su salud.

Paso 4: Su equipo de cuidado traba con usted para asegurar que logr sus objetivos.

Pagos reducidos

Solamente a través de MNsure puedes calificar para pagos reducidos que disminuyan la cuota de tus primas mensuales. Te ayudaremos a ver si tú calificas para un plan gratuito o de bajo costo. Puede ser que califiques también para pagos reducidos de los gastos mensuales de seguro médico, tales como deducibles y copagos.

Ayuda personalizada

La elección de un plan de cobertura de salud puede ser una decisión bastante complicada. Con MNsure, no es necesario preocuparse — puedes llamar a nuestra red de asistentes de consumidores para que respondan a tus preguntas y te guíen para llenar tu aplicación:

- Una red de organizaciones y agentes a través del estado y de tu comunidad.
- Especialistas totalmente capacitados para contacto con el cliente a través de la línea de llamadas gratis.

Pasos simples para obtener cobertura.

Obtener cobertura de salud debería ser un proceso simple y directo.
Con MNsure, lo será.

Con unos pocos pasos simples, tendrás tu cobertura.

Paso 1: Crea una cuenta en línea.
Paso 2: Explica qué necesitas. Te haremos preguntas básicas sobre tu situación y la de tu familia.
Paso 3: Busca un plan. Compara tus opciones por precio, proveedor o servicios ofrecidos.
Paso 4: Reduce tus gastos. Puede ser que califiques para un crédito de impuestos federales, o un plan de seguro médico patrocinado por el estado de Minnesota como, MinnesotaCare o el programa federal/estatal de Asistencia Medica (MA).
Paso 5: Completa tu aplicación. Sólo tienes que llenar una aplicación para ti y tu familia para cualquier tipo de cobertura médica ofrecida a través de MNsure.

No hay dos personas en Minnesota que sean iguales. Pero todas dormirían más tranquilas sabiendo que ellas y sus familias tienen cobertura para los gastos médicos en aumento.

En otras palabras, tener un seguro de salud significa tranquilidad para tu futuro, tu salud, la de tu familia, y tus finanzas.

MNsure.org
Llama gratis
1-855-3-MNSURE (1-855-366-7873)

La inscripción comienza en octubre de 2013.

SPCB0913

En Minnesota hay más de 10,000 razones para obtener seguro médico.

Y ahora hay un lugar nuevo ideal para encontrarlo.

MNsure℠
Donde tú eliges tu cobertura de salud
MNsure.org

Bienvenido a MNsure:

La nueva y mejor forma de obtener seguro médico.

Te presentamos un lugar integral para adquirir seguro médico donde las personas que viven en Minnesota como tú pueden obtener ayuda, comparar, elegir y comprar planes de calidad y a precio razonable dentro de una variedad de planes de seguro médico que se adapte a tus necesidades.

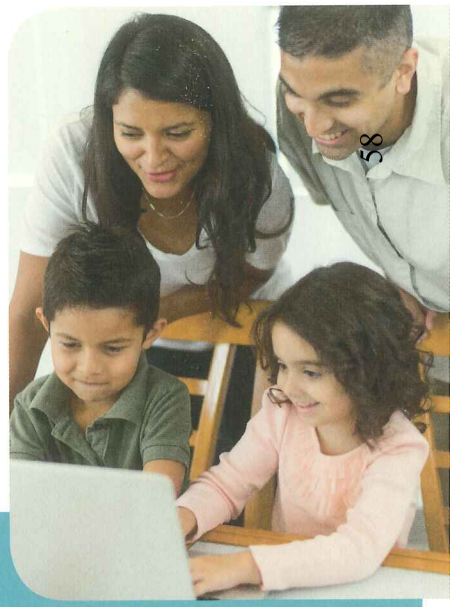
Con la inscripción que se inicia en octubre de 2013, MNsure se convierte en la mejor opción y en el lugar ideal en Minnesota para elegir cobertura de salud. Visita MNsure.org hoy o llama gratis al teléfono 1-855-3-MNSURE para más información.

Busca ayuda

Hay atención personal disponible a través del sitio integral de MNsure o de organizaciones de la comunidad y agentes en todo el estado.

Compara

MNsure simplifica el proceso para que veas los planes y los costos al mismo tiempo. Puedes buscar por precio o por categoría de calidad y ver si tú calificas para un plan gratuito o de bajo costo. También puedes buscar un plan que ofrezca servicios específicos para cubrir tus necesidades de salud. Además, puedes hallar información confiable sobre clínicas y hospitales para comparar su eficacia con otros proveedores.



Elige y aplica

Adiós, a los formularios largos y complicados en papel. El nuevo sistema te guía paso por paso durante la aplicación para que llenes solamente un formulario en línea para ti y tu familia. Si prefieres un formulario en papel para hacer la aplicación, también tienes esa opción.

9. Mantén una vida equilibrada.

Mantén el equilibrio en el hogar, el trabajo, la familia y el tiempo libre. Otras personas ayudan a mejorar nuestras vidas, pero no siempre pueden darnos todo lo que necesitamos.

10. Toma tiempo y práctica.

A veces nos parece que todos los demás son perfectos. Nadie es perfecto. Las relaciones saludables necesitan tiempo de práctica. Todos podemos aprender nuevas formas de mejorar nuestras relaciones.

¿Necesitas más información?

HCMC Social Services,
(Servicios Sociales de HCMC)
Lunes a viernes, 8 am a 4:30 pm
612-873-2255

¿Tu pareja te ha lastimado o amenazado?

MN Domestic Violence Crisis Line,
(Línea de Crisis para la Violencia Doméstica de MN)
1-866-223-1111

¿En crisis?

Crisis Connection,
(Conexión en caso de crisis)
612-379-6363

Hennepin County
Medical Center

DOMESTIC VIOLENCE INTERVENTION PROGRAM

Nuestro agradecimiento especial a la Universidad del Estado de Kansas por su contribución educativa el contenido de esta publicación.

180-07178SP 4/09

Diez consejos para mantener relaciones saludables

(Ten Tips for Healthy Relationships–Spanish)

Hennepin County
Medical Center

Las relaciones saludables nos hacen felices y pueden mejorar nuestras vidas. Las personas que están en relaciones saludables son más felices y tienen menos estrés. Aun cuando todas las relaciones de pareja son diferentes, existen algunas formas básicas de mantener relaciones saludables.

1. Sé tú mismo(a).

Es más fácil y divertido ser tú mismo(a) y no pretender ser alguien o algo diferente. Las relaciones saludables están compuestas de gente sincera. Los demás deben aceptarte como eres. Nadie debe tratar de cambiarte o controlarte.

2. Sé realista.

No siempre podemos ser todo lo que se espera de nosotros. Algunas veces nos sentimos decepcionados. ¡Acepta a las personas tal como son y no trates de cambiarlas!

3. Conversa con tu pareja.

El diálogo es muy importante en cualquier relación; da a entender que:

- Te das el tiempo
- Escuchas con tus oídos y tu corazón
- Haces preguntas
- Compartes lo que sabes
- Eres honesto(a)
- Tienes una mentalidad abierta

4. Acepta lo que se presenta.

Los cambios son parte de la vida misma. La mayoría de nosotros tratamos de que las personas y las cosas se mantengan como nos gustan. En las relaciones saludables ¡está bien que haya cambios!

5. Sé respetuoso(a).

Las parejas tienen opiniones diferentes y toman decisiones diferentes. Valora lo que tu pareja siente y piensa.

6. Cuídate.

Todos queremos hacer felices a los demás. Recuerda hacerte feliz a ti mismo(a). Es bueno que cada uno haga cosas que disfrutan tanto juntos como individualmente.

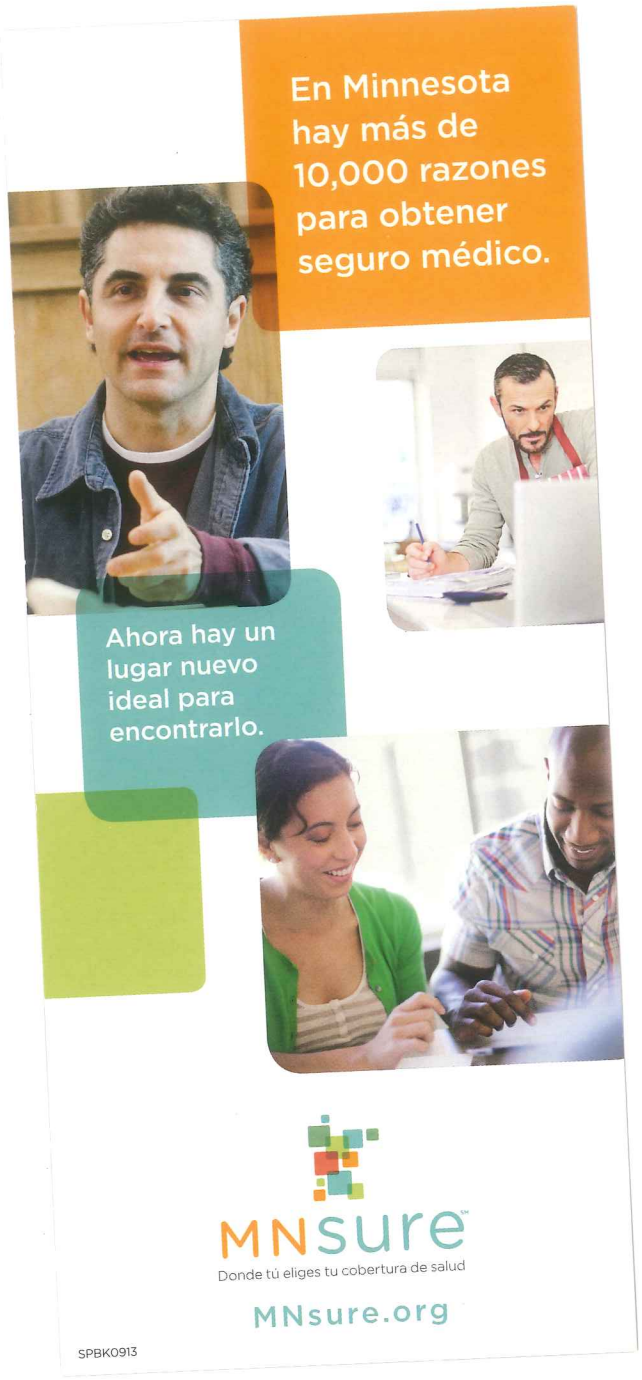
7. Sé digno(a) de confianza.

Si haces planes con alguien, cumple. Si prometes hacer algo, hazlo. Las personas en una relación saludable pueden contar con su pareja.

8. Fortalece la confianza.

Confía y cree en tu pareja.

- Mantén tu palabra
- Sé abierto(a) y honesto(a)
- Asume lo mejor de tu pareja


En Minnesota hay más de 10,000 razones para obtener seguro médico.
Ahora hay un lugar nuevo ideal para encontrarlo.
MNsure
Donde tú eliges tu cobertura de salud
MNsure.org
SPBK0913

Bienvenido a MNSURE: la nueva y mejor forma para obtener seguro médico.

Te presentamos un lugar único e integral para adquirir seguro médico donde las personas que viven en Minnesota como tú pueden obtener ayuda, comparar y elegir dentro de una variedad de planes de seguro médico de diversas compañías para obtener así una cobertura de calidad, a precio razonable que se adapte a tus necesidades y presupuesto.

Puede ser que califiques para un plan de salud gratuito o de bajo costo. MNsure te guiará para que puedas seguir todos los pasos de la inscripción y llenes solamente un formulario para registrarte.

Busca ayuda

La elección de un plan de cobertura de salud puede parecer una decisión bastante complicada. Busca ayuda en tu comunidad a través de una organización o agente de seguros médicos de confianza.

Compara

MNsure simplifica el proceso para que veas los planes y los costos al mismo tiempo. Puedes buscar por precio o por calificación de calidad, y ver si tú calificas para un plan gratuito o de bajo costo. También puedes buscar un plan que ofrezca servicios específicos para cubrir tus necesidades de salud.

Elige

Mira y compara los planes y costos de varias empresas de seguro en el formato simple lado a lado del servicio de MNsure en línea. Elige el plan que cubra tus necesidades.

Tener un seguro médico significa tranquilidad para tu futuro, tu salud, la de tu familia, y tus finanzas.

MNsure.org
Llama gratis
1-855-3-MNSURE (1-855-366-7873)

La inscripción comienza en octubre de 2013.

Síguenos:

- ✓ No quite usted mismo la pintura a base de plomo. Contrate a una persona especialmente capacitada para corregir este tipo de problemas, alguien que sepa hacer este trabajo de una manera segura y que tenga el equipo adecuado para limpiarlo.
- ✓ Todas las personas, especialmente los niños y las mujeres embarazadas, deben salirse del edificio hasta que se haya terminado todo el trabajo y se realice una limpieza a fondo.

5. No traiga polvo de plomo a su hogar.

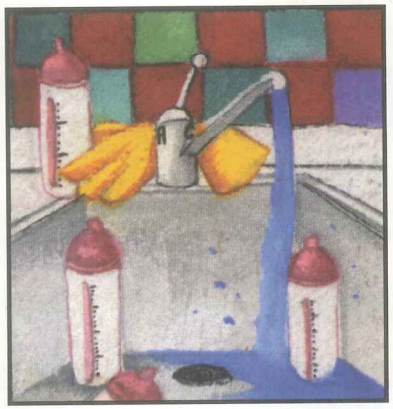
Si trabaja en construcción, demolición, pintando casas, con baterías, en un taller de reparación de radiadores, en una fábrica de plomo o si sus pasatiempos incluyen contacto con el plomo, usted puede traer, sin darse cuenta, plomo a su hogar en las manos o la ropa. Es posible que también traiga plomo a su casa en el polvo de los zapatos. La tierra que está muy cerca de las casas puede estar contaminada con pintura a base de plomo del exterior del edificio. La tierra al lado de las carreteras o autopistas también puede estar contaminada a causa de haber recibido por años los gases de automóviles y camiones que usaban gasolina con plomo.

- ✓ Si usted trabaja con plomo en su empleo o pasatiempo, cámbiese de ropa y báñese antes de regresar a su casa.
- ✓ Es mejor que sus niños jueguen con arena o en la hierba en lugar de hacerlo en la tierra que se pega en los dedos y juguetes. Asegúrese de que sus niños no coman tierra y de que se laven las manos cuando entren a la casa.

6. Elimine el plomo del agua potable.

La mayoría del agua de los pozos o de la ciudad no contiene plomo. Generalmente el agua de su casa recoge plomo adentro de ésta debido a que las tuberías están hechas de materiales que contienen plomo. Hervir el agua no reduce la cantidad de plomo. Bañarse no es un problema porque el plomo no entra en el cuerpo a través de la piel.

- ✓ *La única manera de enterarse si el agua contiene plomo es haciéndola examinar. Llame al Departamento de Salud o a su proveedor de agua para que la examine.*
- ✓ El agua de su casa tendrá más plomo si ha estado largo tiempo en las tuberías, si está caliente o si es naturalmente ácida.
- ✓ Si cree que la tubería de su casa puede tener plomo:
  1) Use solamente agua fría para beber, cocinar y preparar los biberones del bebé.
  2) Deje correr el agua durante 15 a 30 segundos antes de beberla, especialmente si no la ha usado en varias horas.
  3) Llame a la línea directa de agua potable de EPA para recibir más información.



7. Aliméntese bien.

Un niño que toma suficiente hierro y calcio absorberá menos plomo. Los alimentos ricos en hierro son los huevos, la carne roja sin grasa y los frijoles. Los productos lácteos tienen mucho calcio.

- ✓ No guarde comida o líquidos en cristal que contenga plomo o en loza vieja o importada.
- ✓ Si utiliza bolsas de plástico para guardar o llevar comida, asegúrese de que la parte impresa quede en la parte exterior de la bolsa.

Agencia de los Estados Unidos para la protección del medio ambiente
EPA 747-K-00-002
Octubre 2000
Oficina de prevención de contaminación y de substancias tóxicas (7404)

EPA

El Envenenamiento Por El Plomo y Sus Niños

63

Alerta de plomo y sus niños

De acuerdo a los Centros de Control y Prevención de Enfermedades, aproximadamente uno de cada veintidós niños en los Estados Unidos tiene un nivel alto de plomo en la sangre. Puede ser que haya plomo en su edificio sin que usted lo sepa, porque el plomo no se puede ver, oler ni saborear. Es posible que haya plomo en el polvo, la pintura o la tierra que hay dentro y fuera de su casa, en el agua potable o los alimentos. Debido a que no se desintegra naturalmente, si no se elimina, el plomo puede seguir siendo un problema.

Antes de que se descubrieran los efectos dañinos del plomo, éste se utilizaba en la fabricación de pintura, gasolina, tuberías y muchos otros productos. Ahora que conocemos los peligros del plomo, la pintura casera está casi libre de plomo, la gasolina con plomo ha desaparecido y las tuberías caseras no se hacen con plomo.

Cómo afecta el plomo la salud de su niño

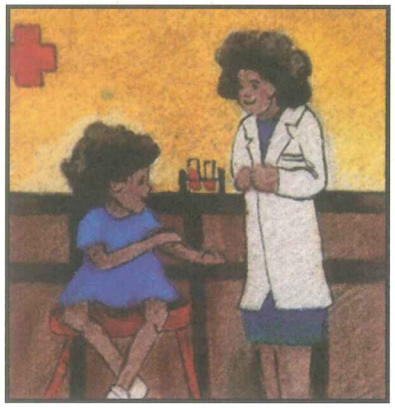
A largo plazo, el plomo puede tener efectos muy severos en su niño. Estos incluyen problemas de aprendizaje, reducción de crecimiento físico, hiperactividad, mal funcionamiento del oído, hasta problemas del cerebro. Si se detectan a tiempo, estos efectos se pueden disminuir, reduciendo el contacto con el plomo y siguiendo un tratamiento médico. Si usted está embarazada, no se exponga al plomo, ya que éste puede pasar a través de su cuerpo al de su bebé. La buena noticia es que hay cosas sencillas que puede hacer para ayudar a proteger a su familia.

1. Hágale a su niño un examen de plomo en la sangre.

Hasta los niños que parecen sanos pueden tener niveles altos de plomo en la sangre. Usted no sabrá si su niño está intoxicado con plomo si no le hace un examen de sangre. Estos exámenes toman solamente diez minutos y los resultados están listos generalmente en una semana.

Los exámenes de sangre generalmente se le recomiendan a:

- ✓ Los niños de uno y dos años de edad.
- ✓ Los niños u otros miembros de la familia que hayan estado expuestos a niveles altos de plomo.



- ✓ Los niños que deberán examinarse mediante un plan local o estatal de muestras de plomo en la sangre.

Para averiguar dónde puede examinar a su niño, llame a su médico o a la clínica de salud pública. Ellos podrán explicarle los resultados del examen y decirle si son necesarios más exámenes.

2. Mantenga la limpieza.

El polvo común y la tierra pueden contener plomo. Los niños pueden tragar o inhalar polvo contaminado si juegan con el polvo o con tierra y luego se meten los dedos o juguetes a la boca, también si comen sin lavarse las manos.

- ✓ Mantenga las áreas de juego lo más limpias y libres de polvo posible.
- ✓ Lave los chupones y los biberones si se caen al suelo. Tenga otros a la mano.
- ✓ Limpie semanalmente los pisos, los marcos y alféizares de las ventanas y otras superficies. Use un trapeador, una esponja o una toalla de papel con agua tibia y un limpiador para usos múltiples o uno hecho específicamente para plomo. RECUERDE: NUNCA MEZCLE PRODUCTOS CON AMONIACO Y BLANQUEADOR YA QUE PUEDEN PRODUCIR GASES PELIGROSOS.
- ✓ Enjuague completamente las esponjas y los trapeadores después de limpiar áreas sucias y con polvo.
- ✓ Lave los juguetes y animales de felpa regularmente.
- ✓ Asegúrese de que sus niños se laven las manos antes de comer y dormir.

3. Reduzca el peligro de la pintura a base de plomo.

La pintura de la mayoría de las casas construidas antes de 1960 contiene plomo. Algunas casas construidas tan recientemente como 1978 también pueden estar pintadas con pintura a base de plomo. Esta pintura puede encontrarse en los marcos de las ventanas, las paredes exteriores de su casa o en otras superficies. Las partículas pequeñas de pintura a base de plomo son peligrosas si se comen. La pintura a base de plomo en buenas condiciones generalmente no es un problema, con excepción de los lugares en donde las superficies pintadas se rozan unas con otras creando polvo. (Por ejemplo: cuando se abre una ventana, las superficies pintadas se rozan entre sí.)

- ✓ *Vigile que su niño no muerda nada que esté cubierto con pintura a base de plomo, como los marcos de las ventanas, las cunas y otros muebles infantiles..*
- ✓ No queme maderas pintadas, ya que la pintura puede ser a base de plomo.

4. No remueva usted mismo la pintura a base de plomo.

Algunas familias se han intoxicado al lijar o raspar la pintura a base de plomo debido a las grandes cantidades de polvo que esto produce. El polvo de plomo puede quedarse en los edificios viejos aun mucho tiempo después de haber terminado las reparaciones o renovaciones. Si se calienta, la pintura de plomo, puede producir vapores de plomo en el aire.

- ✓ Averigüe si el departamento de salud pública local o estatal realiza exámenes de pintura a base de plomo en casas. Algunos lo harán gratis. Bajo ciertas condiciones, los exámenes caseros no pueden detectar las cantidades pequeñas de plomo.

Proteja a sus niños del envenenamiento con plomo

1 Aun cuando el niño esté sano, hágale un examen para asegurarse de que no esté intoxicado con plomo.

2 Limpie semanalmente los pisos, los marcos y los alféizares de las ventanas y otras superficies. Use un trapeador, una esponja o una toalla de papel con agua tibia y un limpiador para usos múltiples o uno hecho específicamente para plomo.

3 Reduzca el peligro de la pintura que contiene plomo. Asegúrese de que su niño no se lleve a la boca nada que esté cubierto con pintura que contenga plomo.

4 No trate de quitar usted mismo la pintura a base de plomo.

5 No traiga polvo de plomo a su casa cuando regrese de su empleo o pasatiempo.

6 Haga examinar el agua. Si no se ha usado el agua fría en dos horas o más, déjela correr durante 15 a 30 segundos antes de beberla o usarla para cocinar.

7 Aliméntese bien y no guarde comida en recipientes de loza que contengan plomo.

El envenenamiento con plomo es un problema serio en la infancia - mientras más pequeño es el niño, mayor es el riesgo.

Para obtener más información llame a:

EPA's Safe Drinking Water Hotline
1-800-426-4791
Información sobre laboratorios certificados para examinar el contenido de plomo en al agua e información sobre filtros

National Lead Information Center
1-800-424-5323
Centro Nacional de Información sobre el Plomo

Visite nuestro sitio Web
http://www.epa.gov/lead

Agencia de los Estados Unidos para la protección del medio ambiente ● Oficina de prevención de contaminación y de substancias tóxicas ● Oficina de agua subterránea y agua potable

CON SU AUTORIZACIÓN

Salvo como se describe en este aviso o como lo requiera o permita la ley, no usaremos ni divulgaremos su información médica sin su permiso. En ocasiones, podríamos pedirle que proporcione un permiso escrito específico para usar o divulgar su información médica. No usaremos ni divulgaremos su información médica por cuestiones de mercadeo, de venta de información médica ni en los casos cuando tenemos que compartir la mayoría de las notas de psicoterapia, a menos que tengamos permiso de parte suya. Si usted nos da permiso, puede retirarlo en cualquier momento enviando una solicitud por escrito al departamento de Administración de Información Médica del HCMC.

REVOCACIÓN DE AUTORIZACIÓN

Si nos da autorización para el uso o divulgación de su información médica, la puede revocar en cualquier momento enviando una revocación por escrito. Sin embargo las divulgaciones que se hayan hecho de conformidad con su autorización antes de revocarla no se verán afectadas por la revocación. Usted puede entregar la revocación al departamento de Administración de Información Médica del HCMC.

SUS DERECHOS

Acceso del paciente. Usted tiene el derecho de inspeccionar y solicitar una copia de su información médica. Si desea tener acceso a su información médica, envíe una solicitud por escrito al departamento de Administración de Información Médica del HCMC. Si usted solicita una copia electrónica de su información médica, trataremos de proporcionarle acceso a su información médica en la forma o formato que usted solicite, si este está disponible en dicha forma o formato. Si su información médica no está disponible en la forma o formato que usted solicita, su expediente se le proporcionará ya sea en nuestro formato electrónico estándar o, si usted prefiere, en una copia impresa legible. Podríamos cobrarle una cuota razonable por los costos de copiar, enviar por correo o por otros suministros asociados con la solicitud, o por el trabajo relacionado con la trasmisión de una copia electrónica, a menos que usted necesite la información para una reclamación por beneficios bajo la Ley del Seguro Social o cualquier otro programa federal de beneficios basado en las necesidades. En ciertas circunstancias limitadas, podríamos rechazar su solicitud. Si le rechazamos su solicitud, le responderemos por escrito. El aviso incluirá la razón y describirá cualquier derecho que usted tenga para una revisión del rechazo.

Cambios. Usted tiene el derecho a solicitar cambios a su información médica, si siente que los expedientes están incorrectos o incompletos. Si desea que se corrija o actualice su información médica, envíe una solicitud por escrito al departamento de Administración de Información Médica del HCMC. Díganos que quiere que se cambie y por qué. Le responderemos por escrito. Si le rechazamos su solicitud, le explicaremos por qué y usted tendrá la oportunidad de apelar dicho rechazo.

Lista de información divulgada. Usted tiene el derecho de solicitar una explicación de ciertas divulgaciones que hemos hecho sobre su información médica. Puede solicitar una explicación enviando una solicitud por escrito al departamento de Administración de Información Médica del HCMC. Su solicitud debe mencionar un periodo de tiempo, el cual no puede exceder de seis años y no puede incluir fechas antes del 14 de abril de 2003. La primera explicación que usted solicite dentro de un periodo de 12 meses será gratuita. Para explicaciones adicionales, le podríamos cobrar por los costos de proporcionarle la explicación. Le avisaremos con anticipación sobre el costo a cubrir.

Aviso de violación de datos personales. Usted tiene derecho a ser notificado si se produce una violación de cualquier información médica suya no protegida.

Restricciones sobre el uso o divulgación. Usted tiene el derecho de solicitar restricciones sobre como usamos y divulgamos su información médica para el pago de tratamientos u operaciones. Puede solicitar una restricción enviando una solicitud por escrito al departamento de Administración de Información Médica del HCMC. En su solicitud, usted debe indicarnos: (1) qué información desea limitar; (2) si quiere y cómo quiere limitar el uso y/o divulgación; y (3) a quién quiere que se le aplique la limitación. No estamos obligados a acceder a sus solicitudes.

Usted también tiene el derecho de solicitar un límite en la información médica que le divulgamos a alguien que participa en su atención médica o en el pago de la misma, como un familiar o amigo. Por ejemplo, usted podría pedir que no compartamos información con su cónyuge sobre un diagnóstico o tratamiento en particular. No estamos obligados a acceder a sus solicitudes; sin embargo, si llegamos a aceptar, cumpliremos su solicitud salvo que la información sea necesaria para un tratamiento de emergencia.

Si usted pagó de su propio bolsillo un artículo o servicio de atención médica específico por completo y ha solicitado que no le facturemos a su plan de salud por ese artículo o servicio, usted tiene el derecho de pedir que su información médica, con respecto a ese artículo o servicio, no sea divulgada al plan de salud para fines de pago o actividades de atención médica. Nosotros respetaremos esa solicitud, salvo que la divulgación sea requerida por ley.

Información alternativa. Usted tiene el derecho de solicitar que le proporcionemos su información médica de manera confidencial. Por ejemplo, usted puede solicitar que le enviemos su información médica por medios alternativos (por ejemplo, dentro de un sobre sellado, en lugar de una tarjeta postal) o a un número telefónico o domicilio alternativo (por ejemplo, llamarle a un número telefónico diferente o enviarle una carta al domicilio de su oficina en lugar de su domicilio normal). Haremos lo posible por cumplir cualquier solicitud razonable.

Copia impresa del aviso. Usted puede recibir una copia impresa de nuestro Aviso de Prácticas de Privacidad vigente.

NEGACIÓN A DAR INFORMACIÓN

La ley permite que usted pueda negarse a dar la información que le solicitamos. Si usted se niega a dar la información, no podremos saber lo suficiente sobre usted para proporcionarle los cuidados que necesita. Además, podríamos tener problemas de facturación que pueden dar como resultado que usted tenga que pagar servicios que de otra manera estarían cubiertos por el seguro, los planes médicos o programas gubernamentales. En algunos casos, si usted no proporciona cierta información, es posible que no podamos atenderlo. Si usted intencionalmente nos da información incorrecta, podría dar como resultado una investigación o cargos por fraude.

PREGUNTAS Y QUEJAS

Si tiene preguntas o dudas sobre la divulgación de su información médica (por ejemplo, acceso a expedientes, restricciones sobre divulgación y revocación de autorización), comuníquese con el Departamento de Administración de Información Médica.

Health Information Management
Mail Code RL.200
ATTN: Health Information Operations Manager
Hennepin County Medical Center
701 Park Avenue
Minneapolis, MN 55415-1676
612-873-3179

Si tiene preguntas o dudas sobre nuestras Prácticas de Privacidad o piensa que sus derechos de privacidad han sido violados, o si tiene una duda sobre cómo hemos usado o divulgado su información médica, comuníquese con el departamento correspondiente.

Para quejas no relacionadas con la privacidad:
Patient Representative Office
Hennepin County Medical Center
Mail Code: R2 .251
701 Park Avenue South
Minneapolis, MN 55415-1676
612-873-8585

Para quejas relacionadas con la privacidad:
Hennepin County Medical Center
Information Privacy & Security Office
ATTN: Privacy Officer
Mail Code: G2.205
701 Park Avenue South
Minneapolis, MN 55415-1676
612-873-3737

También puede enviar su queja por escrito al Secretario del Departamento de Salud y Servicios Humanos de los Estados Unidos ("DHHS"). Si desea hacerlo, envíe la carta a: U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201

No haremos nada en su contra por el hecho de presentar su preocupación o su queja sobre el uso, divulgación o derechos sobre su información médica protegida.

CAMBIOS A ESTE AVISO

Ocasionalmente, podríamos cambiar nuestras prácticas sobre cómo usamos o divulgamos información médica. Nos reservamos el derecho de cambiar los términos de este aviso y de hacer efectivo cambios a toda la información médica que mantenemos. Tenga presente que publicaremos la versión corriente de este aviso en nuestro sitio web, www.HCMC.org, y en lugares fácilmente visibles en todas nuestras localidades. Además, tendremos disponible una copia impresa de este aviso en cada una de nuestras localidades.

180-06183SP 9/13

Aviso de Prácticas de Privacidad

(Notice of Privacy Practices - Spanish)

Fecha de vigencia: 23 de septiembre de 2013

Hennepin County
Medical Center

AVISO DE PRÁCTICAS DE PRIVACIDAD

Hennepin Healthcare System, Inc.

ESTE AVISO DESCRIBE CÓMO PUEDE USARSE Y DIVULGARSE SU INFORMACIÓN MÉDICA Y CÓMO USTED PUEDE OBTENER ACCESO A DICHA INFORMACIÓN. LÉALO DETENIDAMENTE.

NUESTRAS RESPONSABILIDADES

Su privacidad es muy importante.

Con el propósito de brindarle servicios médicos y ayudarle a cuidar de su salud, nosotros obtendremos información sobre usted. Obtendremos y conservaremos cierta información demográfica sobre usted, incluyendo su nombre, número telefónico y domicilio. Es posible que le pidamos cierta información sobre su historial de enfermedades o lesiones, sus antecedentes familiares y demás información relacionada con su salud física o mental. Es posible que recibamos información sobre la atención que usted recibió en otro hospital o clínica por escrito o electrónicamente. Sus médicos y personal médico pueden tomar notas de las observaciones hechas sobre usted y registrar sus resultados de las pruebas clínicas y su historial farmacológico. A toda esta información le llamamos su información médica. Se guarda en su historial médico. También conservamos otros registros relacionados con el costo de su atención médica y el pago de nuestros servicios prestados.

Estamos conscientes de que su información médica es privada para usted. Conservamos información sobre usted para atenderlo y para cumplir requisitos legales y de otro tipo. La ley nos exige proteger su información médica, proporcionarle a usted este Aviso de Prácticas de Privacidad (conocido como Aviso Tennessen), y seguir los términos y condiciones de la notificación actualmente en vigor.

A QUIÉN CUBRE ESTE AVISO

Este aviso cubre a Hennepin Healthcare System, Inc., quien trabaja bajo el nombre de Hennepin County Medical Center ("HCMC"), y sus respectivos departamentos y unidades, personal, voluntarios, estudiantes y residentes. Este aviso también cubre a otros prestadores de servicios médicos que vienen a las instalaciones de HCMC para atender a pacientes (como médicos, terapeutas y demás prestadores de servicios médicos no empleados por HCMC), a menos que estos otros proveedores de servicios médicos le den su propio aviso de prácticas de privacidad que describe cómo ellos protegerán su información médica protegida.

USOS Y DIVULGACIONES DE SU INFORMACIÓN MÉDICA

Nosotros normalmente usamos y divulgamos su información médica de la siguiente manera:

Tratamiento. Podemos usar y divulgar su información médica para prestarle, coordinar o administrar su atención médica y demás servicios o productos relacionados. Por ejemplo, podemos divulgar información sobre usted a médicos, enfermeras, trabajadores sociales, capellanes, y demás profesionales médicos para coordinar y proporcionarle a usted servicios como recetas, análisis clínicos, radiografías o derivaciones.

Pago. Podemos usar y divulgar su información médica para obtener el pago de su atención médica y demás servicios relacionados. Por ejemplo, le podemos informar a su plan médico o a su aseguradora médica sobre el tratamiento que usted ha recibido o que va a recibir con el fin de obtener el pago o para determinar si su seguro médico lo cubrirá.

Operaciones de atención médica. Podemos usar y divulgar su información médica para apoyar nuestros servicios médicos. Esto puede incluir la evaluación y mejoría de la calidad, administración de la atención y la verificación de las cualificaciones de los profesionales médicos. Por ejemplo, podemos usar su información médica para evaluar su atención o satisfacción con nuestros servicios, y usar los resultados para mejorar de manera continua la calidad de la atención, para divulgar su información médica a otras entidades que realizan varias actividades para nosotros, como facturar o auditar, y para divulgarla a otros prestadores que lo han atendido.

Contactos del paciente. En ocasiones, nos podemos comunicar con usted para establecer una cita o recordarle una cita futura, proporcionarle información sobre tratamientos y beneficios o servicios relacionados con la salud que puedan ser de interés para usted.

Socios comerciales. Podemos divulgar información médica a nuestros socios comerciales que realicen funciones de parte nuestra o que nos proporcionan servicios, si la información es necesaria para dichas funciones o servicios. Los socios comerciales tienen la obligación de proteger su información de la misma manera que nosotros.

La gente que participa en su atención. Cuando sea pertinente, nosotros podemos divulgar información médica relevante sobre usted a gente que participa en su atención o que participa en el pago de su atención, como sus familiares, amigos o contactos de emergencia. Si no desea que esta información se comparta, usted puede solicitarlo. En caso de una emergencia, o si usted está incapacitado, nosotros podemos divulgar su información médica, según sea necesario, si determinamos que esto es lo mejor para usted, basado en nuestro juicio profesional.

Recaudación de fondos. Nosotros podemos comunicarnos con usted o nuestra fundación puede comunicarse con usted para recaudar fondos para apoyar la misión de HCMC. Nosotros solo podemos usar y divulgar su nombre, información demográfica e información limitada sobre su atención o servicios (como la fecha de servicio y el departamento que proporciona el servicio). Nosotros podemos divulgar esta información a compañías que nos ayudan a recaudar fondos. No le venderemos su información a nadie. Si nos comunicamos con usted para recaudar fondos y en el futuro no desea ser contactado, se le dará la oportunidad de que su nombre sea eliminado de la lista de contactos.

Directorio del hospital. Conservamos un directorio de pacientes en el hospital y en la sala de emergencias que permite al personal de HCMC confirmar a la gente que pregunta por usted (por su nombre) que usted es un paciente, su habitación y sus condiciones generales. Los representantes de entidades religiosas podrían preguntar sobre su afiliación religiosa, si esa información fue proporcionada. Usted puede optar por ser excluido de nuestro directorio indicándolo en nuestro formulario de Autorización y Consentimiento del Paciente. Si usted no acepta que divulguemos esta información, el personal no podrá dar esa información a ninguna persona que llame por teléfono ni a visitantes (inclusive amigos y familiares) ni a representantes de alguna entidad religiosa.

Investigación médica. La investigación médica es crucial para el avance de la atención y el tratamiento de la salud general. Conforme a la ley, nosotros podemos usar o divulgar su información médica o participar en investigaciones médicas, si es que nosotros eliminamos cualquier información que pudiera identificarlo de manera personal, como su nombre, domicilio o número de registro médico. Sin embargo, no divulgaremos información médica que lo identifique a usted o que pueda usarse para identificarlo para fines de investigación médica sin haber obtenido su consentimiento o sin respetar los procedimientos legales del estado, que exigen hacer un esfuerzo de buena fe para obtener su consentimiento. A menos que usted tenga una objeción, nosotros también nos podemos comunicar con usted para ver si está interesado en participar en ensayos de investigación clínica para los cuales usted puede reunir los requisitos.

Se nos permite o requiere que compartamos su información médica para los siguientes fines:

Fines de salud pública. Podemos divulgar información médica para fines de salud pública, incluso para informar sobre estadísticas vitales (como nacimientos y fallecimientos); para informar sobre reacciones adversas a medicamentos; para avisarle a gente sobre el retiro de productos del mercado; para informar sobre enfermedades y para controlarlas (como el cáncer y la tuberculosis), lesiones o discapacidad; y para informar sobre enfermedades transmisibles.

Abuso y negligencia. Podemos divulgar información a las autoridades correspondientes sobre el abuso o negligencia de un niño o adulto vulnerable.

Actividades de supervisión sanitarias. Podemos divulgar información a agencias de supervisión sanitarias que supervisan nuestras operaciones, incluso a agencias gubernamentales, a las que otorgan licencias, auditoras y de acreditación.

Para evitar una amenaza seria. Podemos divulgar información médica para ayudar a evitar una amenaza seria e inminente para la salud o seguridad de una persona o el púbico.

Operaciones de ayuda comunitaria durante desastres. Podemos divulgar su información médica a organizaciones de ayuda comunitaria para coordinar su atención o para notificar a otros dónde y cómo se encuentra usted en caso de un desastre. Usted tiene el derecho de optar a que no se divulgue la información, si es que nos resulta práctico hacerlo.

Donación de órganos. Podemos divulgar información médica a agencias de donación y procuración de órganos.

Compensación de los trabajadores. Podemos divulgar información médica para cumplir con los requisitos de las leyes de compensación de los trabajadores o programas similares.

Efectos de notificación sobre violación de datos personales. Nosotros podemos divulgar información médica según se requiera para cooperar con las autoridades en investigaciones y para proporcionar avisos legalmente requeridos sobre accesos no autorizados a o sobre información médica.

Personal militar / Actividades de seguridad nacional e inteligencia. Podemos divulgar información médica a autoridades oficiales de las fuerzas armadas o para actividades de inteligencia, contrainteligencia u otras actividades de seguridad nacional.

Instituciones correccionales. Nosotros podemos divulgar información médica de una persona en custodia a agencias del orden público o instituciones correccionales, de ser necesario: i) para la atención médica de la persona; ii) para proteger la salud y seguridad de esa persona y del público, incluyendo a las agencias del orden público; o iii) para la seguridad de la institución correccional.

Orden público. Nosotros podemos divulgar información médica a oficiales de orden público, incluso para identificar a un sospechoso, fugitivo, testigo esencial o persona extraviada; sobre la víctima de un delito (bajo ciertas circunstancias); sobre una muerte que se cree sea el resultado de comportamiento criminal; sobre un delito cometido dentro de nuestras instalaciones; cuando haya una emergencia o para denunciar un delito.

Proceso legal. Podemos divulgar información médica en respuesta a órdenes de la corte o judiciales, citaciones judiciales u otros documentos legales.

Fallecimiento. Podemos divulgar información médica al médico forense, médico investigador o al director de la funeraria para identificar a una persona fallecida, determinar la causa del fallecimiento o lo que se juzgue necesario para llevar a cabo sus deberes, entre ellos los arreglos después del fallecimiento.

Requerido o permitido por ley. Podemos usar o divulgar información médica según lo requiera o permita la ley, incluso, reportar heridas por arma de fuego u otras lesiones que resulten de una acción ilegal.

Información médica y las leyes estatales. Bajo las leyes de Minnesota, la divulgación de registros médicos normalmente requiere el permiso firmado del paciente o de su representante. Entre las excepciones se incluyen cuando usted tiene una emergencia médica, cuando va a ver a un proveedor relacionado y otras divulgaciones requeridas o permitidas por ley.

También participamos en un sistema integral de información médica con otros proveedores y compartimos información médica de nuestros pacientes con esos proveedores. Todos los proveedores participantes han aceptado adherirse a un conjunto de normas relacionadas para el uso y divulgación de información médica disponible a través del sistema. Estas normas tienen la intención de cumplir con todas las leyes estatales y federales. Por ejemplo, otro proveedor participante que le proporcione servicios a usted podrá tener acceso a la información médica suya que compartimos dentro del sistema. Dichos proveedores pueden usar la información médica para pagos, tratamientos y operaciones relacionados con atención médica.

Usted tiene el derecho de ejercer sus derechos.
Puede expresar quejas y recomendar cambios al personal de HCMC o a cualquier otra persona u organización de su elección, sin limitaciones, interferencia, amenazas, discriminación ni abuso. El aviso de procedimiento de quejas de HCMC, así como la dirección y el número de teléfono de la Oficina de Quejas de Instalaciones Médicas de Minnesota (Minnesota Office of Health Facility Complaints), se colocarán en varios lugares en todo el hospital.

Usted tiene el derecho de presentar una queja formal escrita o verbal a HCMC.
Usted debe tener expectativas razonables en cuanto a la atención y los servicios. Nosotros debemos atender esas expectativas de manera oportuna, razonable y consistente.

Si cree que sus expectativas no se han satisfecho, puede presentar una queja con HCMC llamando a la Oficina de Representantes de los Pacientes al 612-873-8585 o puede ir a la Oficina de Representantes de los Pacientes que está ubicada en el primer piso del edificio verde, G1.220.

También puede comunicarse con los siguientes:

Minnesota Office of Health Facility Complaints
P.O. Box 64970
St. Paul, MN 55164-0970
651-201-4201
800-369-7994

Minnesota Board of Medical Practice
University Park Plaza
2829 University Ave. SE, Suite 500
Mpls., MN 55414-3246
612-617-2130
800-657-3709

Office of Ombudsman of Older Minnesotans
P.O. Box 64971
St. Paul, MN 55164-0971
651-431-2555
800-657-3591

El Centro Médico del Condado de Hennepin (Hennepin County Medical Center - HCMC) está acreditado a través de la Comisión Conjunta de Acreditación de Organizaciones de Atención Médica (Joint Commission on Accreditation of Healthcare Organizations - JCAHO). Esta agencia ayuda a asegurar y supervisar la calidad y la seguridad de la atención médica de los pacientes. Si después de comunicarse con HCMC cree que estos asuntos no han sido abordados adecuadamente, siéntase en entera libertad de comunicarse con JCAHO llamando al 630-792-5000 o escribiendo a JCAHO a:
Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Blvd.
Oakbrook Terrance, Il. 60181

Responsabilidades individuales

- **Proporcionar información -** Los pacientes y las familias, como sea apropiado, deben proporcionar, a su mejor saber y entender, información precisa y completa sobre las quejas actuales, enfermedades pasadas, hospitalizaciones, medicamentos y otras cuestiones relacionadas con su salud. Los pacientes y sus familias deben informar los riesgos percibidos en su cuidado y los cambios inesperados en su condición. Pueden ayudar al hospital a entender su ambiente proporcionando opiniones acerca de las necesidades y expectativas de servicios.
- **Hacer preguntas -** Los pacientes y las familias, como sea apropiado, deben hacer preguntas cuando no entiendan su cuidado, tratamiento y servicio, o lo que se espera que hagan.
- **Seguir instrucciones -** Los pacientes y sus familias deben seguir el plan de cuidado, tratamiento y servicios que se ha desarrollado. Deben expresar cualquier preocupación acerca de su habilidad de seguir el plan de atención médica propuesto o el curso del cuidado, tratamiento y servicios. El hospital hace todos los esfuerzos por adaptar el plan a las necesidades y limitaciones específicas de los pacientes. Cuando no se recomienden tales adaptaciones al plan de cuidado, tratamiento y servicios, los pacientes y sus familias son informados de las consecuencias de las alternativas de cuidado, tratamiento y servicios y de no continuar con el curso propuesto.
- **Aceptar las consecuencias -** Los pacientes y sus familias son responsables de los resultados si no siguen el plan de cuidado, tratamiento y servicios.
- **Obedecer las reglas -** Los pacientes y sus familias deben obedecer las reglas del hospital.
- **Mostrar respeto y consideración -** Los pacientes y sus familias deben ser considerados con el personal y los bienes del hospital, así como con otros pacientes y sus bienes.
- **Cumplir con los compromisos financieros -** Los pacientes y sus familias deben cumplir con cualquier obligación financiera acordada con el hospital.

LEY DE PROTECCIÓN DE ADULTOS VULNERABLES

La Ley de Protección de Adultos Vulnerables es una ley de Minnesota que protege de abuso o descuido a los pacientes hospitalizados. Mientras esté hospitalizado en el Centro Médico del Condado de Hennepin, estará protegido por esta ley, y recibirá ayuda del personal si ha sido objeto de abuso o descuido mientras se encuentra en este hospital, en un hogar de ancianos o en su propia casa.

EXPLICACIÓN DE LA INFORMACIÓN QUE SE RECOPILA EN HCMC

Mientras sea un paciente en el Centro Médico del Condado de Hennepin, se le pedirá que proporcione cierta información acerca de su historial familiar, sus hábitos de vida, su historial de enfermedades o lesiones y la información relacionada que el personal que lo cuidará necesita para ayudar en su diagnóstico y tratamiento.

Sus médicos y otro personal también tomarán notas de las observaciones que hagan de usted. Toda esta información y los resultados de cualesquiera pruebas médicas se mantendrán en su expediente médico. Otros expedientes con respecto a los cargos incurridos en el hospital y el pago de dichos cargos también se mantendrán en el hospital, aunque no son parte de su expediente médico. Las leyes de Minnesota disponen que la información de este tipo no puede ser recopilada, utilizada, almacenada ni diseminada (revelada a otros) sin informarle a usted la manera en que HCMC tratará esta información.

De acuerdo con este requisito, los pacientes de HCMC deben estar conscientes de que la información recopilada por el hospital, además de ayudar al personal a proporcionar su atención médica, puede ser revisada por médicos y otras personas para fines de:

- Educación e investigación sobre maneras nuevas y mejores de diagnosticar y tratar enfermedades
- Revisión de la atención médica de los pacientes por parte de agencias de asesoramiento o acreditación
- Asegurar normas de servicio de alta calidad
- Preparación oportuna y precisa de las facturas del hospital
- Satisfacer los requisitos de salud y seguridad pública estatales y federales
- Satisfacer los requisitos legales de proporcionar datos a las agencias que investigan el maltrato de niños y de adultos vulnerables
- Recopilar datos de salud pública y satisfacer las obligaciones de reportarlos como lo requieren las leyes estatales y federales
- Administrar el hospital y para fines legales y de control de riesgos

Las leyes disponen que usted puede rehusar proporcionar la información que el personal de HCMC le solicita para ayudar en su diagnóstico y tratamiento; no obstante, si rehúsa dar esta información, el personal de HCMC no sabrá suficiente sobre usted para proporcionarle el mejor tratamiento. Además, si no suministra suficiente información, esto podría crear problemas de facturación y resultar en que usted tenga que pagar servicios que puedan estar cubiertos por seguros, planes médicos o programas gubernamentales. En algunos casos, si no proporciona cierta información, podría ser imposible para HCMC mantenerlo en el hospital y/o darle tratamiento.

Si es menor de 18 años de edad y la índole de su tratamiento le permite contratar su propio cuidado sin el consentimiento paterno, puede solicitar por escrito que no se provea ninguna información acerca de su tratamiento a sus padres. Usted debe estar consciente de que el personal de HCMC puede proporcionar información a sus padres si se determina que no informar al padre o tutor podría poner su salud en grave peligro.

El Centro Médico del Condado de Hennepin provee igual acceso a programas de empleo y servicios independientemente de la raza, color, creencia, religión, edad, sexo, incapacidad, estado civil, orientación sexual, asistencia pública u origen nacional. Si usted cree que se ha discriminado en su contra, comuníquese con HCMC Human Resources, P1., 701 Park Avenue, Mpls. MN 55415. 612-873-2277

180-02725SP 9/07

DECLARACIÓN DE DERECHOS DE ATENCIÓN MÉDICA

(HEALTH CARE BILL OF RIGHTS – SPANISH)

Hennepin County **Medical Center**

DECLARACIÓN DE DERECHOS DE ATENCIÓN MÉDICA

Como paciente, usted tiene derechos en las instalaciones de atención médica. Los siguientes son sus derechos como paciente en el Centro Médico del Condado de Hennepin (Hennepin County Medical Center - HCMC). Si no puede entender estos derechos o su médico cree que cierta información puede ser perjudicial para su salud, la información se le proporcionará a un miembro de su familia, su tutor o el representante que haya elegido.

Usted tiene el derecho de ser informado.
Cuando sea admitido a HCMC, se le informará sobre la Declaración de Derechos de Atención Médica. Estos derechos lo protegen durante su estadía, durante todo su tratamiento y después de que haya regresado a su casa. El personal de HCMC proporcionará la información por escrito en caso de que desee consultarla más tarde. Se hará todo intento por proporcionar la información a aquellos con problemas de comunicación o a aquellos que no hablan ni leen inglés.

Si solicita información a la Administración de HCMC sobre la política del hospital, los hallazgos de las inspecciones de las autoridades de salud gubernamentales, o una explicación adicional de sus derechos, la información se hará disponible a usted o a su representante si hacerlo no viola ninguna ley.

Usted tiene el derecho a ser tratado con cortesía.
Usted tiene el derecho de ser tratado con cortesía y respeto por su individualidad en HCMC o en cualquier otra instalación médica.

Usted tiene el derecho de recibir atención apropiada.
Usted recibirá la atención médica y personal apropiada basada en sus necesidades. Este derecho se limita a los servicios de emergencia necesarios cuando no haya fondos públicos o privados disponibles para pagar por su atención.

Usted tiene el derecho de saber el nombre de su médico.
Se le dará por escrito el nombre, la dirección comercial, el número de teléfono y la especialidad del médico responsable de su atención general.

Usted tiene el derecho de conocer otros servicios de salud involucrados en su cuidado.
Si recibe servicios de una persona o agencia que no es parte del HCMC, tiene el derecho de saber el nombre del proveedor externo, la dirección y una descripción de los servicios que reciba.

Usted tiene el derecho de saber acerca de su diagnóstico y tratamiento.
Su médico le dará información completa y actualizada acerca de su diagnóstico, tratamiento, alternativas, riesgos y posibles resultados. Esta información será en palabras que usted pueda entender. Un miembro de la familia, amigo o representante puede estar presente cuando su médico le proporcione esta información, Usted también tiene el derecho de rehusar escuchar esta información.

Si tiene cáncer del seno, será informada completamente de todos los tratamientos alternativos durante su estadía en el hospital. Estos incluyen cirugía de varios tipos combinada con terapia radiológica (rayos X) y/o quimioterapia (terapia con medicamentos). También se le informará de los riesgos asociados con cada tipo de tratamiento.

Usted tiene el derecho de participar en la planificación de su cuidado.
Cuando los médicos y otros profesionales de la salud planeen su cuidado, usted tiene el derecho de tomar parte en las decisiones que se tomen. Tendrá la oportunidad de hablar sobre el tratamiento y las alternativas, solicitar una conferencia formal sobre el cuidado que incluya a todo su equipo de atención médica, así como a un miembro de su familia o un representante de su elección.

Si no puede comunicarse cuando sea admitido al HCMC, se harán esfuerzos por comunicarse con un miembro de su familia o un representante que usted haya elegido por anticipado y por escrito. A esa persona se le permitirá participar en la planificación de su tratamiento y podría tomar su lugar en cualquier conferencia.

HCMC permitirá que un miembro de su familia participe en la planificación de su tratamiento, a menos que se sepa o haya motivo para creer que usted ha indicado por anticipado o por escrito que no desea a ningún miembro de la familia involucrado en su tratamiento.

Los esfuerzos por notificar a un miembro de su familia o representante podrían hacer que sea necesario examinar sus efectos personales, examinar sus expedientes médicos o preguntar a un miembro de su familia o a su médico regular si usted ha designado un representante.

Si el personal no puede comunicarse con un miembro de su familia o su representante dentro de las 24 horas después de haber sido admitido, el hospital notificará a la agencia de servicios sociales del condado o a la agencia del orden público local (autoridad competente). Esas agencias ayudarán a comunicarse con un miembro de su familia o con su representante.

Usted tiene el derecho de recibir cuidado continuo.
En la medida que lo permita la programación, será atendido por el personal que lo conoce y está familiarizado con sus necesidades.

Usted tiene el derecho de rehusar la atención médica.
Basado en la información que su médico le proporcione, usted puede rehusar el tratamiento.. Si no puede entender las consecuencias de su rechazo, o si ha sido juzgado legalmente incapaz de tomar decisiones sobre su cuidado, HCMC podrá proveer tratamiento sin su consentimiento. El médico documentará en su expediente médico las circunstancias exactas que condujeron al tratamiento sin su consentimiento.

Usted tiene el derecho de rehusar participar en investigaciones experimentales.
Si se le pide ser parte de un experimento de investigación médica, tiene el derecho de decir que no sin ninguna consecuencia para usted. Esto se documentará en su expediente médico. Si conviene en participar en la investigación, se le pedirá que firme un formulario de consentimiento que le informará de los beneficios y riesgos del tratamiento.

Usted tiene el derecho de no ser maltratado.
Como paciente en HCMC, estará libre de cualquier abuso mental o físico, descuido o explotación financiera. Abuso se define en la Ley de Protección de Adultos Vulnerables como una agresión, explotación sexual, violación sexual, agresión sexual, dolor intencional y no terapéutico, lesión, o causar intencionalmente aflicción mental o emocional.

Usted tiene el derecho de estar libre de reclusión y restricciones de cualquier forma impuestas como un medio de coerción, disciplina, conveniencia o represalia por parte del personal.
Tiene el derecho de estar libre de medicamentos que no ayudan a su condición y de restricciones físicas innecesarias para su protección. Si cualquiera de estas restricciones son necesarias para protegerlo a usted o a otros, HCMC documentará completamente por qué fue necesaria. Además, estas restricciones sólo se utilizarán por un tiempo limitado como lo especifique un médico.

Usted tiene el derecho a la privacidad.
El respeto y la privacidad en su atención médica y personal son su derecho en HCMC. Si su equipo de atención médica necesita hablar sobre su cuidado, consultar a otros profesionales, examinarlo, o tratar su condición esto se hará de forma confidencial y discretamente. Se respetará la privacidad cuando usted use el inodoro, lo bañen, o cuando le provean otro cuidado personal, excepto cuando necesite ayuda para su seguridad.

Usted tiene el derecho de que se mantenga la confidencialidad de sus expedientes de paciente.
Su atención médica es confidencial y su consentimiento debe obtenerse antes de que sus expedientes puedan darse a cualquiera fuera de HCMC. Este derecho no aplica a investigaciones de quejas realizadas por el Departamento de Salud, a información necesaria para pagos hechos por terceros como Medicare, o a otra información que requiera la ley.

Usted tiene el derecho de obtener acceso a la información contenida en sus expedientes clínicos dentro de un período de tiempo razonable.
Se le permitirá inspeccionar y obtener una copia de la información de su salud que mantiene HCMC. HCMC sólo retendrá información en circunstancias limitadas.

Usted tiene el derecho de saber qué servicios se incluyen en su factura.
Antes o durante su admisión a HCMC, se le dirá qué servicios se cubren en la tarifa diaria de habitación del hospital y cuáles están disponibles por un cargo adicional. HCMC hará todos los esfuerzos por ayudarle a saber si los cargos son cubiertos por Medicare o Medical Assistance.

Usted tiene el derecho de recibir un servicio receptivo.
El personal de HCMC le proporcionará respuestas prontas y razonables a sus preguntas.

Usted tiene el derecho a la privacidad personal.
No importa cuál sea su raza, color, creencia, religión, edad, sexo, incapacidad, estado civil, orientación sexual, asistencia pública u origen nacional, usted tiene derecho a la privacidad y el respeto.

Usted tiene el derecho de hablar en privado con su familia, amigos u otros representantes que haya elegido.
Mientras se encuentre en HCMC, puede hablar en privado con cualquier persona que elija y entrar y salir del hospital como lo desee, a menos que hacerlo pudiera ser perjudicial para su salud o seguridad. La única excepción a esto es si ha sido confinado al hospital bajo la Ley de Confinamiento de Minnesota. Habrá materiales para escribir y sellos postales a su disposición, a sus expensas. Usted recibirá todo su correo personal sin abrir, a menos que su médico haya documentado que hacerlo podría empeorar su salud. Habrá un teléfono disponible para que haga y reciba llamadas privadamente, a menos que un médico haya documentado que las conversaciones telefónicas podrían ser perjudiciales para su salud.

Usted tiene derecho a sus bienes personales.
Puede tener su propia ropa y posesiones en el hospital si el espacio lo permite o los derechos de otros no se ven afectados, las reglas de seguridad no son violadas y su médico no ha indicado que es perjudicial para su salud.

Usted tiene el derecho de rehusar proporcionar servicios para el hospital.
Mientras esté en el hospital, no se le pedirá que realice ningún trabajo para beneficio de HCMC, a menos que sea parte de su programa de terapia con los objetivos escritos en su expediente médico.

Usted tiene el derecho de consultar a un defensor o una agencia de abogacía.
Es su derecho el acceso razonable en horas razonables a un defensor o servicios de abogacía. Podrá hablar en privado con el representante de su elección.

Para pacientes hospitalizados, pacientes en la sala de emergencia, pacientes en observación y pacientes ambulatorios de cirugía del mismo día:
Tiene el derecho de solicitar que la información concerniente a su identidad, fecha de admisión y condición general se mantenga confidencial. Si elige esta opción, HCMC no podrá transferirle llamadas ni reconocer su presencia aquí, incluso a sus amigos y parientes.